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Original Article

Comparing the effectiveness of quality of life therapy and compassion-focused therapy on the quality of interpersonal relationships and distress tolerance in women with marital conflict

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Abstract

Introduction: The present study aimed to compare the effectiveness of quality of life therapy and compassion-focused therapy on the quality of interpersonal relationships and distress tolerance in women with marital conflicts.

Materials and Methods: The statistical population of this clinical trial concluded all married female students with marital conflicts, who referred to counseling center of Islamic Azad University of Mashhad in the first half of the academic year (2019-2020). Amongst them 45 students were selected by convenience sampling and assigned into two experimental groups and one control group randomly (n=15). For data collection, Simmons and Gaher´s Distress Tolerance Questionnaire and Pierce, Sarason, and Sarason Quality of Relationships Inventory (QRI) were used. For data analysis, SPSS software and repeated measures analysis of variance were applied.

Results: According to the calculated F (F=286.27) which is lower than the F criterion at the 0.05 level, both types of treatment have been effective in distress tolerance index and the quality of interpersonal relationships. In the variable of the quality of interpersonal relationships, the quality of life skills have had better results compared to the compassion-focused therapy and in the variable of distress tolerance, the compassion-focused therapy has had better results than the quality of life skills; but the difference between the groups is not significant (P>0.05).

Conclusion: Based on the results, quality of life therapy and compassion-focused therapy have significant effects on family mental health, such as the quality of interpersonal relationships and distress tolerance.

Keywords: Compassion, Distress, Interpersonal relationships, Quality of life, Tolerance.

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Introduction

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Family is considered as one of the main institutes of society and is among the most important places for the development of human spirit. A mutual understanding between couples empowers family (1). The quality of marital relationships includes a variety of factors such as the extent of adjustment, satisfaction, happiness, cohesion, emotional-sexual intimacy and commitment (2). This dimension is an important predictor of continuity, stability and endurance and the cause of success and function of a healthy and happy marriage; it is also a process by which the degree of marital conflict, closeness, and agreement and decision-making is determined (3). In an emotion-based approach, marital conflicts occur when couples fail to meet each other's attachment needs (security, safety, satisfaction); i.e. marital distress indicates the couple's failure to establish a relationship with a secure attachment style (4). Based on the evidences, there is a high rate of comorbidity between marital conflicts and anxiety states (5). One of these variables is distress tolerance (6). This term has been conceptualized as a meta-emotion and is regarded as an attribute, not an emotional state (7). Distress tolerance is an important factor in coping with difficulties. According to the theory by Simmons and Gaher, distress tolerance has been defined as the inability to fully overcome the annoying and distressing emotional experience, the capacity to experience and tolerate negative psychological states and the individual's tendency to exhibit a negative reaction to ambiguous events and situations, independent of the probability of the occurrence or its associated consequences. This variable is called the manner of people's response to negative affect (9). Distress may be caused by physical and cognitive processes, but its representation is emotional. According to the research by Kazemian and Esmaili, non-divorced women reported better status in terms of the dimensions of communication patterns and distress tolerance and they were more satisfied while divorced women with conflicts had more chaotic communication patterns compared to non-divorced women and they were at a lower level in distress tolerance (11). Success in adulthood is achieving emotional development and adequacy in interpersonal relationships is tied to their emotional experiences in the original family (12). Cognitive patterns of marital conflicts indicate deficiencies in the processing of information in these individuals. There are negative and dysfunctional thoughts and distortions in the cognitive processes of information processing of individuals with conflicts that lead to a high sense of responsibility for a future disaster or danger (13). Further, the results of the conducted researches suggest that there is a significant relationship between the low quality of interpersonal relationships and marital conflicts (5). The quality of interpersonal relationships, in addition to being related to anxiety, is significantly correlated with depression accompanied by lack of pleasure (14). Undoubtedly, it can be mentioned that one of the most important issues in the process of human development is the quality of interpersonal communications (15). Cognitive theories (e.g., Beck's Cognitive Theory of Depression) have provided evidence for the effects of cognitive distortions and negative thoughts on the incidence of interpersonal conflicts. Interpersonal theories (e.g., Coyne's Interactional Theory of Depression) emphasize the role of interpersonal processes in the quality of interpersonal relationships (16). The use of the integrated cognitive-interpersonal approach focuses on examining the interaction between intrapersonal and interpersonal factors. Attachment theory is one of these integrated theories (17). According to the ethological theory, attachment is an important factor in the quality of interpersonal relationships in subsequent years of one's life (18). The quality of interpersonal relationships with others is one of the experiences in life that engage people mostly. It is important to everyone that having good friends and establishing good relationships with parents, important people in the environment and spouses (19). Moreover, there is considerable evidence that such intimate and supportive relationships can have positive consequences. Poor interpersonal relationship is one of the most stressful experiences of life (20).

Various forms of psychological therapies have been developed to address the problems of people with conflicts. In this research, we use the quality of life therapy and compassion-focused therapy. One of the methods that can be considered is the quality of life training. According to Frisch, with respect to the definition provided by the World Health Organization, it can be said that the quality of life training is an approach based on positive

psychology, cognitive therapy and quality of life theory. This theory proposes five methods or patterns for life satisfaction as a plan for quality of life and interventions, which is called quality of life training and therapy (21).

Based on the conducted studies, the quality of life therapy can be effective in the reversibility of patients with bipolar disorder (22). Besides, in a research conducted, it was revealed that quality of life skills training is effective in self-efficacy of dialysis patients (23). Given this effectiveness reported in the field of quality of life skills training, it is necessary to conduct a research on the quality of interpersonal relationships and distress tolerance of women with conflicts, which is one of the serious problems of the current Iranian society. One of the new and popular psychotherapies is the compassion-focused therapy. Self-compassion was developed by Paul Gilbert in response to the observation that many people, especially those with shame and self-criticism, had difficulty in creating the kind and self-supportive inner voice. Neff and Germer define self-compassion as a three-component construct, including the following: Self-compassion vs. self-judgment, human commonalities vs. isolation and mindfulness vs. extreme assimilation. Today, the combination of these three related components is a characteristic of the individual who has self-compassion (24).

According to the study, it was found that compassion-focused therapy is effective in improving cognitive regulation of individuals (25). Moreover, the research indicated that compassion-focused therapy is an effective group intervention for improving some mental health problems (26).

Based on the foregoing and with regard to the importance of the issue of marital conflict, since every day we see an increasing number of clients, especially women, coming to family counseling clinics and given that the domestic and foreign studies related to quality of life therapy and compassion-focused therapy have been further focused on disorders, lack of comparative study of the effectiveness of these two relatively new approaches draws more attention relative to other cases that may prove fruitful.

Given these cases and since there have been no studies to compare the effectiveness of compassion-focused therapy and quality of life therapy in the quality of interpersonal relationships and distress tolerance, it seems necessary to carry out this research.

Materials and Methods

The research statistical population of this clinical trial comprised all married female students with marital conflicts, who referred to Mashhad Azad University counseling center in the first half of the academic year of 2019. Considering that a sample of at least 15 individuals is considered in the experimental study (27), the statistical sample included 45 cases were selected by convenience sampling and were randomly assigned into three groups. This research approved by the Islamic Azad University of Neyshabur with the ethical code IRJAU.MSHD.REC.1398.228. The first experimental group received quality of life therapy based on Frisch therapeutic protocol; the second experimental group underwent compassion-focused therapy based on Gilbert therapeutic model and the third group was assigned in the waiting list as the control group. The sessions of both types of therapeutic interventions were held by the researcher. After the end of the experiment, all three groups were post-tested. Then, two months after the posttest, the follow-up test was performed. The research inclusion criteria were willingness to participate in the research, aged 20 years and older, being married, having marital conflicts, being an undergraduate student and above, not having chronic mental or physical illness and not having history of treatment related to quality of life improvement. The exclusion criteria were as follows: announcing withdrawal from the research, receiving simultaneous psychological treatments and having another mental disorder.

Research instrument

A) Simmons and Gaher´s Distress Tolerance Questionnaire: This scale consists of 15 items and 4 subscales. The subscale of tolerance is measured by questions 1, 3 and 5; the subscale of attraction by questions of 2, 4 and 15; the subscale of assessment by questions 6, 7, 9, 10, 11 and 12 and the subscale of regulation by questions 8, 13 and 14. This questionnaire is scored on a 5-point Likert scale, including strongly agree, slightly agree, no idea, slightly disagree and strongly disagree. Each option has a score of 1, 2, 3, 4 and 5. Expression 6 is reverse scored. High scores represent high distress tolerance. In the research by Hawkins et al. (28), the internal consistency

of this scale was estimated to be 0.91. In Iran, Cronbach's alpha coefficients reported equal to 0.75, 0.77, 0.70 and 0.75 for each of the subscales, respectively (29). Besides, the validity coefficients of the Distress Tolerance Scale through correlations with positive emotions, negative emotions and the tendency to smoke were 0.54, -0.22 and -0.65, respectively.

B) Pierce, Sarason, and Sarason Quality of Relationships Inventory (QRI): This questionnaire has been developed by Pierce, Sarason and Sarason. It contains 29 items but in the next edition, 4 items were removed and eventually 25 items remained. It is scored on a 4-point Likert scale, including none, low, medium and high. This scale includes three subscales of social support (7 items), importance and depth of relationships (8 items) and interpersonal conflicts (14 items). The support dimension measures the extent to which a person is available to help when problems arise. Depth is designed to measure the importance of a relationship in one's life and the conflict dimension assesses negative emotions such as anger and a sense of guilt. Pierce et al. reported its reliability coefficient between 0.75 and 0.92 through test-retest method on 94 male students and 116 female students with a two-week interval (30). In Iran, content validity has been approved by several psychologists. The test-retest reliability was obtained 0.83 for the whole questionnaire and above 0.70 for the subscales. Further, in each of the 25 items, the individual should assess the quality of his relationships with parents, friends and spouse (31).

Eight 90-minute therapy sessions were held according to the protocol adopted based on the book "Quality of life therapy" by Michael Frisch (32).Summary of quality of life therapy sessions First session: Communication and introduction of members, statement of the group rules, introduction of the training course, discussion about the quality of life, life satisfaction, happiness and well-being. Second session: Assignment review, definition of quality of life therapy, introduction of quality of life dimensions, introduction of the tree of life to the group members. Third session: Assignment review, introduction of CASIO as five roots (circumstances, attitudes, standards of fulfillment, importance and overall satisfaction). Fourth session: Assignment review, discussion about CASIO, discussion about attitude. Fifth session: Assignment review, introduction of the standards we have set for ourselves, values, overall life satisfaction. Sixth session: Assignment review, discussion about the principles of quality of life, presentation of principles and explanation of the application of these principles to reduce cognitive distortions and increase psychological well-being. Seventh session: Assignment review, discussion about the scope of relationships, and the application of important principles in the scope of relationships. Eighth session: Providing a summary of the content of previous sessions, summarizing and teaching CASIO generalization in different life situations and application of principles in different aspects of life (32).

Objectives, content, and interventions used in the sessions of this study were based on the books "compassion-focused therapy for therapists" (33) in eight 70-minute sessions, the summary of which is as follow:

First session: Establishment of a therapeutic relationship with clients, definition of compassion, introduction of and familiarity with the treatment. Second session: Mindful breathing training, compassionate mind training, focus on empathy for sympathetic understanding of matters, greater sensitivity to issues to increase care for and attention to one's health. Third session: Explanation of the three emotional systems of threat, relief and drive and how they work, soothing breathing training. Fourth session: Visualization training, use of the question "what happens if you can have self-compassion?", training of forgiveness and acceptance of one's mistakes and self-forgiveness. Fifth session: Soothing breathing and visualization of compassion and kindness to others (close people, strangers or even animals and plants), visualization of acceptance of compassion from others. Sixth session: Learning to accept changes and endure difficult and challenging circumstances with regard to the changing lifestyle. Seventh session: Strengthening parts of the self that can grow and change and be healing such as self-compassion with the compassionate chair technique, resilience, identifying values that give meaning to life, being responsible for one's actions. Eighth session: Naming emotions and feelings with compassion and kindness, doing exercises and visualizations learned in real life.

Results

Table 1 presents the demographic variables of the participants. Mean and standard deviation of the scores of distress tolerance in pretest, posttest, and follow-up phases are presented in Table 2.

Table 1. The demographic characteristics of the students

		Control group		Quality of life therapy		Compassion-focused therapy	
Variable	**Classification**	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Education level	Bachelor's degree and undergraduate student	8	53.33	7	46.67	8	53.33
	Master's degree and above	7	46.67	8	53.33	7	46.67
Employment status	Governmental jobs	7	46.67	6	40	7	46.67
	Non-Governmental Jobs	4	26.67	5	33.33	6	40
	Housekeeping	4	26.67	4	26.67	2	13.33
Children	Yes	9	60	10	66.67	6	40
	No	6	40	5	33.33	6	40
Duration of marriage	Less than 5 years	8	53.33	7	46.67	6	40
	Between 5 and 10 years	6	40	6	40	6	40
	More than 10 years	1	6.67	2	13.33	3	20
Age group	< 30 years	2	13.33	3	20	2	13.33
	30-40 years	11	73.34	10	66.67	10	66.67
	40-50 years	2	13.33	2	13.33	3	20

The findings in the table above indicate that 15 women have participated in each of the three groups, who have been classified based on academic degree in two groups of university education (bachelor's degree and undergraduate student and master's degree and above). They were almost homogeneous in terms of education level and had very little difference. Of the 45 participants in the study, 20 were government employees, 15 had non-governmental jobs and 10 cases were housewives. The subjects were classified into three categories based on age group where out of 45 individuals, 31 were within the range of 30-40 years.

Homogeneity of the sample under study in demographic terms will lead to desirable validity of the results. In fact, the two factors of education and age will not influence the results of each group and are controlled. Table 3 presented the results of Mauchly's sphericity test.

Table 2. Mean and standard deviation of the scores of distress tolerance in pretest, posttest, and follow-up phases

Variable	**Group**	**Pretest**		**Posttest**		**Follow-up**	
		M	SD	M	SD	M	SD
Tolerance	Control	9.13	1.76	9.20	1.32	9.93	1.62
	Experimental 1	9	1.92	11.86	1.30	12.33	1.23
	Experimental 2	9.20	1.61	12.26	1.62	12.86	1.59
Attraction	Control	7.73	1.27	8	1.51	8.40	1.54
	Experimental 1	7	1.73	11.13	1.40	11.67	1.39
	Experimental 2	7.46	1.50	12.13	1.72	12	1.13
Assessment	Control	18.93	2.12	19.33	2.12	19.53	2.41
	Experimental 1	19.20	1.85	22.73	2.05	23.13	2.13
	Experimental 2	19.13	1.72	24.73	2.57	23.40	3.08
Regulation	Control	7.60	1.80	7.75	1.72	7.67	2.38
	Experimental 1	7.73	2.21	11.73	2.31	12.33	2.02
	Experimental 2	7.93	1.83	13.13	1.72	12.67	2.35
Distress tolerance (total score)	Control	43.40	3.58	44.06	4.008	45.53	3.73
	Experimental 1	42.93	5.39	57.46	4.03	59.47	3.99
	Experimental 2	43.73	3.84	62.26	4.90	60.93	4.44
Social support	Control	18.53	3.66	19.33	3.08	20.53	3.50
	Experimental 1	18.13	3.97	28.06	3.69	29	3.38
	Experimental 2	18.06	3.47	24.53	3.41	25.73	3.01
Importance and depth of relationships	Control	15.20	2.48	15.66	2.91	16.80	3.09
	Experimental 1	14.93	3.19	24.60	3.13	23.67	2.96
	Experimental 2	14.80	3.54	21	3.29	21.53	1.92
Interpersonal conflicts	Control	38.13	3.96	39.86	5.82	39.60	5.66
	Experimental 1	38.40	4.15	48.93	5.28	45.86	6.34
	Experimental 2	38	3.29	44.80	4.39	46.67	3.90
Quality of relationships (total score)	Control	71.86	4.86	74.86	8.64	76.93	8.97
	Experimental 1	71.46	7.86	101.60	8.49	98.53	8.62
	Experimental 2	70.86	4.89	90.33	7.95	93.93	6.18

Experimental 1: Quality of life therapy Experimental 2: Compassion-focused therapy

Table 3. Results of Mauchly's sphericity test

		Mauchly's sphericity statistic	Chi-square statistic	Degree of freedom	Significance level	Greenhouse and Geyser	Epsilon Huynh-Feldt	Lower domain estimation
Quality of life therapy	Distress tolerance	0.811	5.641	2	0.060	0.841	0.921	0.500
	Quality of relationships	0.610	3.363	2	0.201	0.719	775	0.500
Compassion-focused therapy	Distress tolerance	0.850	4.397	2	0.111	0.869	0.955	0.500
	Quality of relationships	0.799	6.05	2	0.058	0.833	0.911	0.500

Scale	Source of effect	Sum of squares	Degree of freedom	Mean square	F	Significance	Eta squared
Quality of interpersonal relationships	Stage	9700.93	2	4850.46	179.232	0.001	0.810
	Stage*Group	3363.82	4	840.956	31.075	0.001	597
	Error	2273.24	84	27.062			
	Group	2060	2	1030	27.477	0.001	0.567
	Error	1574.40	42	37.486			

P<0.05, **P<0.01

The results of Table 3 indicate that there is a significant difference between the experimental groups and control group in the mean posttest and follow-up scores of the quality of interpersonal relationships (P<0.05). After doing Tukey's post hoc test, it was found that there is a significant difference between the control group and each of the experimental groups in the posttest and follow-up scores (Table 4).

Table 4. Tukey's post hoc test to compare the mean of the research variables in groups

		Posttest Subset α = 5٪			Follow-up Subset α = 5٪	
Variable	Group	1	2	3	1	2
Quality of interpersonal relationships	Control	74.86			76.93	
	Compassion-focused therapy		90.33			98.53
	Quality of life therapy			101.60		93.93

Based on the post hoc test results, the quality of interpersonal relationship follow-up scores in the experimental group (1) who received quality of life therapy decreased compared to the posttest, but still they are significantly different from the control group scores. Hence, the efficacy of both treatments is confirmed and better results are obtained in the posttest scores of quality of life therapy compared to the compassion-focused therapy.

Table 5. Repeated measures analysis of variance to compare the effectiveness of treatment methods in distress tolerance

Scale	Source of effect	Sum of squares	Degree of freedom	Mean square	F	Significance	Eta squared
Distress tolerance	Stage	4048.17	2	2024.08	286.27	0.001	0.872
	Stage*Group	1635.91	4	408.97	57.844	0.001	0.734
	Error	593.91	84	7.07			
	Group	1087.022	2	573.51	55.14	0.001	0.724
	Error	413.933	42	9.856			

*P<0.05, **P<0.01

The results of Table 5 suggest that there is a significant difference between the experimental groups and control group in the mean posttest and follow-up scores of distress tolerance (P<0.05).

After doing Tukey's post hoc test, it was determined that there is a significant difference between the control group and each of the experimental groups in the posttest and follow-up scores.

Table 6. Tukey's post hoc test to compare the mean of the research variables in the groups

		Posttest		Follow-up	
		Subset α = 5٪		Subset α = 5٪	
Variable	Group	1	2	1	2
Distress tolerance	Control	44.06		45.53	
	Quality of life therapy		57.46		59.47
	Compassion-focused therapy		62.26		60.93

Based on the results of Table 6, the post hoc test has improved in the posttest and follow-up scores of distress tolerance in the experimental group (2) who received compassion-focused therapy compared to the pretest. It is inferred that although compassion-focused therapy has improved women in the posttest phase, the difference between the experimental groups is not significant and both treatments have had the same results in the distress tolerance index. Therefore, the efficacy of both treatments is confirmed and although the posttest scores of compassion-focused therapy were better than those of quality of life therapy, the difference between the groups is not significant.

Discussion

The purpose of the present study is to compare the effectiveness of quality of life therapy and compassion-focused therapy in the quality of interpersonal relationships and distress tolerance of women with marital conflicts. This research demonstrated that there is a significant difference between the subjects in the posttest scores of quality of life therapy and compassion-focused therapy. According to the test results, the quality of interpersonal relationships in the first experimental group who received quality of life skills decreased compared to the posttest, but it is significantly different from the control group. Thus, the effectiveness of both treatments is confirmed and the posttest scores of quality of life skills were better than those of the compassion-focused therapy.

The findings of this research are in line with the results of studies by Shujuan et al. who approved the effectiveness of quality of life skills training in self-efficacy of patients with intestinal stoma (34). Soltannezhad's study confirmed the effectiveness of quality of life skills training in self-efficacy in dialysis patients (23). These results are also congruent with the findings of this study. The results of the research carried out by Farid Hosseini et al. concerning the effectiveness of quality of life skills training in the reversibility of patients with bipolar disorder are in line with the findings of the current study (22). It can be stated that quality of life therapy is effective in anxiety states, the quality of interpersonal relationships and distress tolerance of women with conflicts since these people have a type of self-preoccupation that is characterized by self-underestimation and uncertainty about their own abilities, mostly leading to negative cognitive assessment and negative emotions (35). According to Dinner's theory, emotions, feelings and judgments related to satisfaction are adaptive and provide permanent feedback for individual purposes.

Positive and pleasant emotions come from the understanding that one has achieved and fulfilled his needs, goals and desires while negative emotions indicate obstacles or recessions in the realization of valuable areas of life. Thus, the quality of life therapy, by focusing on people's cognition which is an important component in the treatment of anxiety and distress, enables the subjects to view the existing experiences from a different perspective associated with different fields. In this way, the individual is able to achieve a better definition of self and considers the problem as an overarching experience and solves it in an appropriate way (36).

The quality of life therapy is performed by making cognitive-behavioral changes in five main areas (living conditions, attitudes, satisfaction criteria, values and overall life satisfaction) (25). The quality of life therapy teaches people that life is of different aspects and that if they are dissatisfied with an aspect, they should consider other aspects.

By teaching the principle of inner richness along with its specific assignments, they learn how to feel focused, relaxed, and joyful by devoting enough time to themselves, how to put aside their bad habits and plan to revitalize themselves and enhance the quality of interpersonal relationships (25). Therefore, this treatment can affect the quality of interpersonal relationships in several ways. On the other hand, compassion-focused therapy promotes

kindness, self-understanding and avoidance of self-criticism and negative judgment about oneself. The findings of this study are consistent with the results of studies by Cappage, Baird and Gibson who confirmed compassion-focused therapy as an effective group intervention for some mental health problems (26). Ahmad Pourdizaji, Zahrakar and Kiyamanesh found that compassion-focused therapy is effective in improving cognitive regulation of individuals (25). As stated by Neff (37), people with a high degree of compassion toward self and others are kinder and try to understand events. It should be mentioned that compassion-focused therapy facilitates the acceptance of positive feedback and enhances the ability to deal with neutral feedback. Studies have shown that people with high self-compassion show greater psychological health compared to people with low self-compassion because in such individuals, the inevitable pain and the feeling of failure that everyone experiences do not continue by a cruel self-blame, a sense of isolation and extreme assimilation with thoughts and emotions (38).

Moreover, the findings of this research are somewhat consistent with studies showing that the presence of a compassionate attitude in individuals helps them feel a bond between themselves and others and overcome the fear of rejection and incompatibility with the present situation due to this feeling (39).

Thus, people with higher self-compassion, in experiencing adverse events such as aggression in interpersonal relationships, show less negative emotions and have higher distress tolerance while considering that all humans may make mistakes and make wrong decisions (40). It should be noted that according to the test results, in the quality of interpersonal relationships, quality of life therapy has had better results compared to compassion-focused therapy and in the variable of distress tolerance, compassion-focused therapy has had better results relative to quality of life therapy.Among the limitations of the research are short duration of the research, difficulty in generalizing the results to other groups except the statistical population, the effect of repeated test execution, lack of random selection of subjects and so on. Hence, it is recommended that this study be replicated by other researchers in different societies with different cultures in order to enhance the generalizability of the results. Given that the effectiveness of education and training techniques requires more time to respond, the results should be interpreted more cautiously. It is also suggested that in future studies, different cognitive levels be considered independently and appropriate research plans be designed in this regard. Additionally, it is recommended to run training courses on quality of life skills and compassion in families in a systematic way and publish a training booklet on quality of life skills and compassion among families.

Conclusion

The research findings demonstrate that the quality of life and compassion approaches can improve the quality of interpersonal relationships and distress tolerance of women with conflicts. Therefore, comparison of the effectiveness of these approaches in the field of marital conflicts and the quality of interpersonal relationships and distress tolerance is one of the innovations of this study.

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