Effectiveness of Acceptance and Commitment Therapy (ACT) on Depression in Women with Marital Conflicts

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Abstract

The purpose of this research was determination of the effectiveness of acceptance and commitment therapy on depression in women with Marital Conflicts in Isfahan. The research used a semi-experimental study with a pretest-posttest-follow-up design and a three months. For this purpose, 40 women were selected by purposeful sampling from women who had referred to psychological Clinics. They were randomly divided into two groups of experiment and control. Both groups were tested for marital satisfaction and depression both before and after the training (10 sessions for 2 hours) and 3 months later. Results of the variance analysis showed a significant reduction of depression at the posttest and follow-up stage (P<0.002). The findings confirm the efficacy of acceptance and commitment therapy on depressed women with marital conflicts.

Keywords: acceptance and commitment therapy, marital satisfaction, marital conflict.
Introduction

Women constitute the integral part of the family and their mental and physical health directly impacts on the mental and physical health of the family and training the children (Ghorbani, 2008). The global Hygiene Organization has introduced women’s health among the criteria of the country’s being developed (Babanazari, 2007). The quality of marital relationships are considered significant anticipation factor for health (Beach, Fincham, & Katz, 2009). Depression, marital conflicts, and low life quality interact with each other in a complex way. Although multiple factors of formation and stability of the conflicts and reduction in the life quality and marital satisfaction have been proposed (Arabnejad et al, 2015), researches have shown the conflicted relationships lead to problems in physical and mental health. In addition, there is some association between marital problems, the level of marital conflicts, and repression symptoms (Beach, Fincham, & Katz, 2009).

Depression is a set of different psychological symptoms which appears in the range from the weak sense of being bored to silence and avoiding daily activity and is among the most common psychological disorders and exists conspicuously as a global hygiene problem in all cultures (Kaplan & Sadock, 2015). According to the Global Hygiene Organization, depression holds the fifth rank of expenditures, which has been estimated that it would become the second disease after heart and tube problems threatening the human’s health and life all over the world (Global Hygiene Organization, 2015). Its spread among women is almost twice men and it has held the highest life length spread_ around 17 percent_ among psychological disorders (Kaplan & Sadock, 2015). This disorder leads to personal and family harms, vocational and interpersonal destruction, and basically lack of concentration on the normal living. On the whole, in terms of the impacts of depression based on the Global Hygiene Organization’s emphasis, depression is the second major cause of inability and disorder in the person’s performance among all the problems related to personal health (Global Hygiene Organization, 2004; Quoted by Cooper, 2009). The existence of the spouses’ problems can have unpleasant impacts all the family members. With the improvement of the today world and machinist life and reduction of interpersonal relationship, the amount of depression and its spread has turned to increase. Similarly, epidemiological studies have shown that 18% of women are suffering from conflicts and lack of mutual understanding in the family (Beach, Fincham, & Katz, 2009).

Although there is agreement on depression as a multi-caused phenomenon, and there is also some evidence presented, which states that lack of social support and closeness with the influential people of life plays an important role in formation of depression, more than one half of the patients with the disorder of depression are facing the function of moody and problematic family Sayers, Kohn, Fresco, Bellack & Bellack, Sarwer, 2001).

With the increase in marital conflicts, incompatibility increases; more dissatisfaction is cause; and on the whole, these problems are the initial steps to divorce (Yong & Long, Iynn, 2006).

On the other hand, the researches on the destructive impacts of marital conflicts show that they have destructive impacts on the health of the body, mind, and family (Fincham, & Beach, 2003). In addition, marital conflicts are related to important effects in the family such as inefficient bringing up children, children’s weak compatibility, and increase in parent-child conflicts (Grish
Many psychological disorders are under mutual effects of marital conflicts, low living quality, and stressful interpersonal relationships (Burrell, Allen, Gayle, & Preiss, 2014). In other words, the low quality of marital relationships is correlated with the disorder of depression, disorder in performance, and low self-confidence. Patients with the depression disorder not only suffer from the symptoms of depression but depression also disturb their life and performance and the results thereof directly impact on the person’s relationships with other family members (IsHak, Balayan Bresee, Greenberg & Fakhry, 2013).

Through a research on the correlation of depression and marital conflicts by Horwitz, Howell (1996), it was shown that the constant decrease of depression symptoms is correlated with the reduction of marital conflicts and the increase in support of marriage process. The research trend in recent years has shown that decrease of depression symptoms is associated with the increase in marital satisfaction, decline of conflicts, and rise of living quality (Burrell, Allen, Gayle, & Preiss, 2014). Marital conflicts are a major threatening cause of psychological disorders such as depression, stress, bipolar disorder, alcohol addiction, and several fatal diseases. A study by Beach, Fincham & Katz, 1998 showed that there is some correlation between the low level of marital satisfaction and women’s depression symptoms. For this reason, the cause of women’s depression can be that of unsuccessful romantic relationship and unsuccessful marriages (Glasser, 2004). In addition, Gollan, Fridman, and Miller (2002) gained high correlation between disturbed relationships and the spouses’ depression. Experimental findings show that women in unsuccessful marriages are depressed three times as men, 46% vs. 15%, which is almost one half of women getting depressed in unsuccessful marriages. Researches stated that if spouses can manage conflicts in a positive way and can be able to solve them, the many conflicts are not harmful (Siffert & Schwarz, 2010).

As per healing intermediaries, inefficient attitudes in formation and stability of depression have been considered by many scholars. Inefficient attitudes are cognitive predicates which relate to fragility, stability, and return of the depression disorder (Bohlmeijer, Fledderus, Rokx & Pieterse, 2011). Therefore, due to the importance of this disorder and its deep effects on the person and family, broad cures with different approaches are offered hereon and this is developing. In conventional cognitive-behavioral therapies (CBT), cognitive reformation and thoughts amendment are used for healing. This method is effective to some extent in reducing symptoms but since it does not aim at living quality and the shortages of this disorder, the symptoms remain there and turn into return (Hayes, 2008). The researches done also lie in the reduction of symptoms as recovery criterion. This view on therapeutic effectiveness is a quantitative view and considers only the symptoms of depression and has less focus on other factors, than reduction of symptoms, such as the living quality (Abedi, Izadi, 2012). In terms of healing effects, it seems that in both the conventional cognitive-behavioral therapy and acceptance and commitment therapy, ACT, which is considered among the third wave of behavioral therapy, improvements are gained in reduction of depression symptoms but the significant point is that maintaining the healing improvements in the ACT method is much more
ACT approaches cognition based on a behavioral theory about language and cognition, which is named the relational frame theory, RFT, (Heyes, Strosahl & Wilson, 1999). According to RFT, the human does not respond to stimuli based on merely its interaction with them in the past _the idea which is emphasized by behavior-orientation_ but the response also depends on the mutual relationships of the stimuli with other events (Hayes & Strohshal, 2004). On the whole, RFT regards mental defects as problems with the lingual field in which the person experiences inner events, rather than the problem with the content, form, or the number of those inner events (Heyes, Strosahl & Wilson, 1999). The purpose of ACT is movement from psychological inflexibility towards psychological flexibility. Six central processes which lead to the psychological flexibility include acceptance, projection, one-self as the field, relationship with the present time, clarifying values, and committed act. Arabnejad et al stated that through these major six processes during the ACT healing process over the spouses, “due to the rise of psychological flexibility, we see some increase in the satisfaction and quality of the marital life as well as some decrease in the marital conflicts with a consistent impact (Arabnejad et al, 2015).”

Many of the clinical symptoms of the depression disorder such as repetitive and self-focused thought, beliefs, memories, physical feelings, low character and temper, especially the aspects which are associated with the possibility of disorder return, are suitable for ACT (Folke, 2012). By the emphasis on these signals by ACT methods, it is thought such that not only the possibility of return would decline, but highlighting other issues such as living quality, satisfaction and intimacy in life, social and vocational functions would also increase. Since depression threatens the healthy life of the person, family, and society, it can impact on people’s character, behavior, attitude, and performance negatively, and repercussions such as addition and suicide can involve them (Glasser, 2004). So work on this disorder especially due to its impacts on the couple and family seems to be essential. On the other hand, 50% of the depressed women face marital conflicts and among 50% of the women with marital conflicts, depression has been reported (Beach, Fincham & Katz, 2009). Therefore, since this disorder is more wide-spread among women than men, the necessity of this research is revealed more than before. With regard to the points mentioned above, the main question of the research is “is ACT effective for depression in women with marital conflicts?”

**Method, Statistic Society, Sample**

The method used in this research is semi-experimental with a pretest-posttest-follow-up design of three months (test at three stages). The statistical society of this research includes all the depressed women with marital conflicts, who had referred to one of the three centers of psychological services and consultancy on family and marital conflicts in the city Isfahan. With regard to the entrance criteria (recognition of depression disorder, marital conflicts, the marriage period being between 3 and 15 years, age range of 21 to 45 years old, graduation from middle school up to bachelor’s), they were selected and put in test groups (ACT) and control group randomly.
Examination Devices

For examining depression, the second revised form of Beck Depression Inventory (BID-II) including 21 questions on an answering scale of 0 to 3 was used. This questionnaire, on the whole, covers the two aspects of emotion and cognition in terms of depression which have some average correlation with each other (r=0.57) (Storh, Roberti, Roth, 2004; Ball, ranieri, Beck 1999; quoted by Izadi et al, 2012). In Iran, Dobson and Mohammadkhani (2008) reported on the narrative coefficient being 0.91. Ghasemzadeh, Mojtabaei, Karamghadiri, and Ebrahimkhani (2005) reported on this questionnaire as with Cronbach’s Alpha Coefficient equal to 0.87 and the re-test coefficient equal to 0.74 (p<0.001) (Izadi et al, 2012). The stability of this test in the present research was measured 0.94 according to Cronbach’s alpha.

For examining marital conflicts, the marital conflict questionnaire (MCQ) by Sanaei (2000) was used, assessing eight aspects proposed about marital conflicts including cooperation decline, sexual intercourse decline, rise in attraction of impulsive reactions, increase of attraction of the child’s support, increase of personal relationship with one-self’s relatives, decrease of personal relationship with the spouse’s relatives and friends, separating financial affairs from each other, and reduction of effective relationship. According to Sanaei’s report (2000), a total score showing the total amount of marital conflicts is gained from the sum of these eight micro-scales. The stability of this test in the present research was measured 0.79 based on Cronbach’s alpha.

The method of execution and analysis

The pretest in this research was carried out after the implementation of the selective interview, according to the structured interview based on DSM-V, implementation of Beck depression questionnaire and the marital conflicts questionnaire, and before starting ACT for the test group. Implementation of ACT in this research is based on the lessons and protocol presented for this type of healing endorsed by valid references (Heyes, Strosahl & Wilson, 1999; Hayes, Strosahl, 2010; Twohig, Hayes, Masuda, 2009; quoted by Izadi et al, 2012).

For the posttest, implementation of questionnaires and research devices were carried out one week after the last ACT session.

As per the follow-up, the participants in both the test and control groups answered the research questionnaires again three months after the last ACT session.

The summary of ACT sessions is as follows.

The first session: explaining therapeutic sessions, goals and path of the healing, stating the type of the relationship, general examination of the depression. The second session: examining the healing function of assignment presentation. The third session: introducing the inner and out world and the rules dominating them. The forth session: elaborating control as the problem. The fifth session: introduction of good and bad feelings and tendency instead of control. The sixth session: introduction of one-self as the field and projection. The seventh session: introduction of projection and mind-consciousness practices. The eighth session: understanding the specification of commitment and tendency. The ninth session: introduction of values and introducing the difference between value and goal, practicing examination and determination of values. The
tenth session: practices for commitment. The end of the healing and avoiding return (the three month follow-up): basically, once change in the behavior happened towards the values and several goals were accomplished, the healing should be ended; the follow-up sessions which lasted for three months were 60 minutes each.

The data used resulted from one-parameter and multi-parameter co-variance analysis and the tests related to presumptions of this type of analysis, including parameters’ change normality, equivalence of intra-group or error variances, equivalence of the steepness of regression lines and independence of dependant parameters. All the analyses were carried out by the software Statistical Package for Social Sciences, Version 18.

Findings

In Table 4-1, the indices related to the normality of the distribution of depression scores among the research groups have been presented.

Table 4-1: results of Kolmogroph-Smirneph’s Test and Levene’s Test in depression

<table>
<thead>
<tr>
<th>Levene’s Test</th>
<th>Kolmogroph-Smirneph’s Test</th>
<th>Stage</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sig F</td>
<td>Sig Z</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.94 0.005</td>
<td>0.27 1</td>
<td>Pretest</td>
<td>Depression</td>
</tr>
<tr>
<td>0.002 11.1</td>
<td>0.08 0.72</td>
<td>Posttest</td>
<td></td>
</tr>
<tr>
<td>0.32 1.03</td>
<td>0.001 0.29</td>
<td>Follow-up</td>
<td></td>
</tr>
</tbody>
</table>

As seen in Table 4-1, depression among the both research groups has both the normal distribution (p > 0.05, except for the follow-up stage) and equivalence of error variances (p > 0.05, except for the posttest state).

In Table 4-2, the results of Mauchy’s Test has been presented as the default equivalence of variance of differences at the three stages so as to carry out the variance analysis with the repeated value.

Table 4-2: the results of Mauchy’s Test for studying variance of differences as to carry out the variance analysis of the repeated measurement

<table>
<thead>
<tr>
<th>Epsilon</th>
<th>Lower-bound</th>
<th>Huynh-Feldt</th>
<th>Greenhouse-Geisser</th>
<th>Sig df</th>
<th>Approx chi-square</th>
<th>Mauchy’s W</th>
<th>Effect between the tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>1</td>
<td>0.96</td>
<td>0.45</td>
<td>2</td>
<td>1.59</td>
<td>0.958</td>
<td>Effect between the tested</td>
</tr>
</tbody>
</table>
As seen in Table 4-2, the equivalence of the variance of differences at the three stages has been followed so as to carry out the analysis of the variance of the repeated measurement (p<0.05).

In Table 4-3, the average and standard deviation of the three stages on depression among the test and control groups of the research has been presented.

Table 4-3: results of multi-parameter tests in analyzing the variance of repeated measurement

<table>
<thead>
<tr>
<th>Effect</th>
<th>Statistic Index</th>
<th>F</th>
<th>df</th>
<th>Sig</th>
<th>Mean square</th>
<th>Sum of squares</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Test (pretest, posttest, follow-up)</td>
<td>Pillai’s Effect</td>
<td>34.77</td>
<td>2</td>
<td>0.001</td>
<td>1483/66</td>
</tr>
<tr>
<td></td>
<td>Wilks Lambda</td>
<td>34.77</td>
<td>2</td>
<td>0.001</td>
<td>4934/41</td>
<td>9868.83</td>
</tr>
<tr>
<td></td>
<td>Hoteling’s trace</td>
<td>34.77</td>
<td>2</td>
<td>0.001</td>
<td>6.68</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roy’s largest Root</td>
<td></td>
<td>34.77</td>
<td>2</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interaction of test – group (control – test)</td>
<td>Pillai’s Effect</td>
<td>123.51</td>
<td>2</td>
<td>0.001</td>
<td>120.08</td>
</tr>
<tr>
<td></td>
<td>Wilks Lambda</td>
<td>123.51</td>
<td>2</td>
<td>0.001</td>
<td>6.68</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hoteling’s trace</td>
<td>123.51</td>
<td>2</td>
<td>0.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roy’s largest Root</td>
<td></td>
<td>123.51</td>
<td>2</td>
<td>0.001</td>
<td></td>
</tr>
</tbody>
</table>

In Table 4-3, the results of analyzing the variance of the repeated measurement for the intra-test or intra-group factor (pretest, posttest, and follow-up) and the interaction between the intra-test or intra-group factor and the inter-group factor (control and test group) have been presented.

Table 4-4: the results of analyzing the variance of the repeated measurement for the intra-test or intra-group factor (pretest, posttest, and follow-up) and the interaction between the intra-test or intra-group factor and the inter-group factor (control and test group) over depression scores

<table>
<thead>
<tr>
<th>Effect</th>
<th>Observed power</th>
<th>Partial Eta Squared</th>
<th>Sig</th>
<th>F</th>
<th>Mean square</th>
<th>df</th>
<th>Sum of squares</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test (pretest, posttest, follow-up)</td>
<td>1</td>
<td>0.49</td>
<td>0.001</td>
<td>36.11</td>
<td>1483/66</td>
<td>2</td>
<td>2967.33</td>
</tr>
<tr>
<td>Interaction of test – group (control – test)</td>
<td>1</td>
<td>0.76</td>
<td>0.001</td>
<td>120.08</td>
<td>4934/41</td>
<td>2</td>
<td>9868.83</td>
</tr>
</tbody>
</table>

As seen in Table 4-4, there is meaningful difference in depression among pretest, posttest, and follow-up (p < 0.01). The square of Partial Eta Square is 0.49 and states that 49% of the depression difference between pretest, posttest, and follow-up is related to ACT. In addition, interaction of the test and group (control and test) is meaningful in terms of depression (p < 0.01) so that there is meaningful difference between pretest, posttest, and follow-up in the group of control and test. For the test’s interaction with the group (control and test), the square of Partial
Eta Square equals 0.76, stating that 76% of the difference between pretest, posttest, and follow-up for control and test groups is related to ACT. In Table 4-5, the results of analyzing the one-way variance for comparison of the control and test groups have been presented.

Table 4-5: results of analyzing the one-way variance between the control and test groups by depression

<table>
<thead>
<tr>
<th>Observed power</th>
<th>Partial Eta Squared</th>
<th>Sig</th>
<th>F</th>
<th>Mean square</th>
<th>df</th>
<th>Sum of squares</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>0/7</td>
<td>0/25</td>
<td>0/03</td>
<td>4/15</td>
<td>408/8</td>
<td>1</td>
<td>408/8</td>
<td>Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>98/51</td>
<td>38</td>
<td>3743/43</td>
<td>Error</td>
</tr>
</tbody>
</table>

As seen in Table 4-5, there is meaningful difference by depression between test and control groups (p < 0.05). The square of Partial Eta Square is equal to 0.25, stating that 25% of the difference by depression between the control and test groups is related to ACT. The test power has been 0.7, showing that analyzing the done one-way variance has been able by 70% of the power to recognize the depression difference between the test and control groups.

Therefore, based on the results from tables 4-2 and 4-5, the research question on whether ACT impacts on reduction of depression among women is positively endorsed.

Discussion and Conclusion

The findings on the impact of ACT on depression stated that this healing method has meaningful impact on reduction of depression in women with marital conflicts, as the test group of the present research who were under training and cure by ACT held fewer symptoms of depression at both stages of posttest and follow-up versus the control group who lacked the training and healing by ACT. Therefore, it can be concluded that therapeutic acceptance and commitment hold relatively more consistent impacts on reduction of depression amount.

The findings in this section of the research are conforming to those by Hor et al (2012) and Rafeei et al (2013) in Iran as well as those by Bohlmeijer, Fledderus, Rokx & Pieterse (2011), Forman, Goetter, Herbert & Park (2012), Folke (2012), and Walser, Karlin, Trockel & Mazina (2013) outside Iran stating that therapeutic acceptance and commitment is effective on people with different problems and disorders. Similarly, in support of this therapeutic approach, the results from the research done as effectiveness of healing depression based on mind-consciousness (Kaviani et al, 2005; †2005Kenny, Williams, 2007†Madathil & Benshoff, 2008) could be cited.

In conceptualization of depression by ACT, it is stated that depressed people have experimental prevention, cognitive merging, interest in conceptualized self, lack of relationship with the present moment, unclear values, and lack of participation in valuable activities. In simple words, all the six core and major processes in therapeutic acceptance and commitment (acceptance, projection, self as the field, being in the present, values, and committed activity) have problems in depressed people. Such problem with the six processes, in the first place, causes a depressing
mental-lingual atmosphere in people. Two special features of depression one of which should exist to recognize such problem are unhappy and low character (sadness, or anxiety) and lack of interest and joy towards normal activities and daily hobbies. To recognize depression, both of these symptoms should exist in most of the day (Twohig, Hayes, Masuda, 2009).

Other depression symptoms include loss of attention and happiness in daily activities, major disorder and change in appetite and body weight, disorder in sleep as under-sleep or over-sleep, disorder in thinking and focus thereof, anxiety and slowness of movements, feeling valueless or guilty, lack of power or energy and tiredness, and repetitive thoughts of death or suicide (Bohlmeijer, Fledderus, Rokx & Pieterse, 2011). If we do not say that some defect is seen in all the six processes of ACT, it can be claimed that some defect is seen therein at least about lack of interest and joy towards normal activities and daily hobbies, loss of attention and happiness in daily activities, disorder in thinking and focus thereof, feeling valueless or guilty, lack of power or energy and tiredness, and repetitive thoughts of death or suicide.

A second elaboration which is a supplement to the first is related to the fact that besides cause of a depressing mental-lingual atmosphere, the defect in the six processes is quite able to increase psychological inflexibility. Perhaps one of the reasons that a definite and permanent healing for depression has not been proposed and implemented so far is the ignorance of this reality that basically, the psychological inflexibility has not been considered corresponding to the consistency it has among depressed people. Similarly, this fact may have been due to this fact that the skills proposed and used in cognitive and behavioral healings prior to ACT have not had the essential and adequate power to decrease and relieve the psychological inflexibility. Involvement in effective and constructive processes (acceptance, projection, one-self as the field, relationship with the present time, clarifying values, and committed act) for increase of psychological flexibility can reduce depression symptoms well (Twohig, Hayes, Masuda, 2009).

For instance, when the person is involved with the improvement of the process “self as the field” he is encouraged to experience themselves in different ways than the past, rather than challenging the value of beliefs). The improvement of the process “focus on values” takes place by emphasis and focus in the person on this point that values are lingual phrases which approve some particular behaviors and disapprove some others; therefore, this special value-making for behavior, in turn, increases particular behaviors which compete with the disapproved ones such as experimental prevention. And for the improvement of the process “committed acts”, determination of special, valuable, approved behaviors which have been conspicuous in the process of focus on values is emphasized.

For this reason, it seems that through improvement of the central processes proposed in therapeutic acceptance and commitment, a form of intra-mental challenge between the cognitive-behavioral symptoms and depression and the processes under improvement including acceptance, projection, one-self as the field, relationship with the present time, clarifying values, and participation in valuable activity (committed act) is caused and as ACT proceeds more, the depression symptoms reduce in this challenge by disconnection of the solid and inflexible mental-lingual processes_ taking place due to the improvement of psychological flexibility_ from the symptoms. This elaboration shows well that how therapeutic acceptance and
commitment is able to decrease depression among women with marital conflicts in an intermediary way, through raising the level of psychological flexibility.

The last elaboration on the impact of therapeutic acceptance and commitment which is essential to be noticed is the fact that according to the researched done, depression is associated with a set of symptoms which affect people’s social and vocational performance and lead to damage to the conditions and quality of life. From this viewpoint also, when the challenge between the six positive processes of therapeutic acceptance and commitment and depression symptoms leads to the most relief of depression symptoms, through raising the psychological flexibility, a positive process of mental-social reaction is also very likely to occur, meaning that having improved the person’s characteristic and behavioral conditions which is caused by the decrease of depression symptoms, the person, on the one hand, will see her more effective and more active performance versus the past and on the other hand, will receive positive reactive signals from the surrounding people stating her considerable changes.

Through a more concrete elaboration among depressed women with marital conflicts, this process can be reviewed in the midst of the effectiveness by therapeutic acceptance and commitment well. The depressed women who have marital conflicts or the related symptoms, including cooperation decline, sexual intercourse decline, rise in attraction of impulsive reactions, increase of attraction of the child’s support, increase of personal relationship with one-self’s relatives, decrease of personal relationship with the spouse’s relatives and friends, separating financial affairs from each other, and reduction of effective relationship, once the smallest improvement signals are shown, are faced with approvals and positive reactions from the spouse and children due to depression conditions which are visible to great extent by the people around, what is common to many other depressed patients who show the improvement of their beliefs and behaviors right though the healing process or after that. A spouse whose spouse’s behavioral pattern has been based on quarrel, conflict, and then experimental prevention for ages is very likely to say “how positively your character and behavior have changed since you have taken the healing” once he sees a smallest change in his spouse’s character and behavior, which would give her the motive and energy needed for raising the capacity of acceptance, commitment, and keeping the process of healing on.

On the whole, it can be stated generally that many clinical symptoms of depressions are potential for return considerably. For several theoretical and practical reasons (improving the person’s positive mental-lingual ability in a different way than what has occurred towards formation and deterioration of depression, raising the person’s psychological flexibility and creating and improving the field for receiving positive social feedbacks) which were mentioned in the elaborations, the acceptance and commitment therapy method (ACT) is suitable for challenging and relieving those symptoms.
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