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The Effectiveness of Domestic Violence-Focused Couples Treatment on Marital Violence, Mental Health, and Sexual Intimacy of Couples with Marital Maladjustment

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Abstract

Introduction: The present study aimed to investigate the effectiveness of Domestic Violence-Focused Couples' Treatment (DVFCT) on marital violence, mental health, and sexual intimacy of couples with marital maladjustment.

Method: A single-case non-concurrent multiple-baseline design was adopted. The statistical population comprised all volunteering couples with marital maladjustment visiting counseling centers in Ahvaz (Iran) in 2021. After screening, two eligible couples (4 people) were purposively selected. The therapy protocol was administered to all the participants in two phases (18 intervention sessions) and four stages (baseline, intervention, a 45-day first follow-up, and a three-month second follow-up.) The participants were assessed before the therapy, on sessions 4, 8, 12, 16, and 18, and on the 45-day and 3-month follow-up. The Symptom Checklist-90-Revised, Couples' Sexual Intimacy Questionnaire, and the Violence against Women Questionnaire were used to collect data. The data were analyzed visually using the reliable change index and the improvement percentage formula.

Results: The DVFCT significantly improved mental health and sexual intimacy and reduced marital violence, an effect that persisted through the follow-up stages ($p < 0.001$).

Conclusion: The present study achieved promising results concerning the applicability of DVFCT. This therapy can thus mitigate couples' marital violence and promote their mental health and sexual intimacy.

Keywords: Couples Therapy, Domestic Violence, Mental Health, Marriage

Introduction

Despite all the efforts made in the early stages of marriage to protect the unity of the family and perform marital duties, couples' love and affection subside over time and may even disappear as a result of negligence [1, 2]. Instead of constructive principles and methods, these couples use non-constructive and destructive strategies to communicate, known as domestic violence [3]. Violence against women is defined as any gender-based violent behavior that causes women physical, sexual, or psychological harm or suffering [4]. Such behaviors can involve threatening, coercion, or absolute deprivation of free will and liberty in public or private. According to this definition, violence against women encompasses a range of coercive physical, psychological, or sexual acts used against women by their current or former intimate partners [5]. The World Health Organization (WHO) reports that 14-74% of women in developing countries and 24% of women in developed countries have experienced violence from their spouses at least once [6]. According to Aktaş et al. [7],

women who have experienced domestic violence consistently report lower levels of satisfaction and intimacy. Domestic violence and rape lead to the loss of health of women aged 15-44 years more than diseases such as breast and uterine cancer, painful childbirth, and accidents. It also harms women's safety and mental health [8].

Mental health is a state of well-being in which people realize their potential, can cope with stressors, work productively, and participate in the society [9]. Mental health involves physical, mental, and social well-being and is not limited to the absence of disease. A large body of family studies has focused on the impact of domestic violence on the mental health of individuals, especially the victim. According to Sesar et al. [10], couples engaging in domestic violence have higher-risk behavioral tendencies, which oddly enough turn into a behavioral habit among family members. Experiencing violence from an intimate partner increases the symptoms of depression, anxiety, and suicidal ideation [11].

Intimacy is a high-level universal and biological need of all human beings. It refers to closeness and similarity in romantic or emotional relationships and requires deep knowledge and understanding of the other person to express thoughts and feelings as a source of similarity and closeness [12]. Marital intimacy refers to closeness, similarity, and romantic/emotional-affective interpersonal relationships with another person (the spouse), which naturally requires deep knowledge and understanding of the other party and leads to the expression of thoughts and feelings between them, thereby indicating their similarity [13]. A lack of marital intimacy can impact couples' psychological, emotional, and physical satisfaction with their relationship and seriously endanger mental health in marriage, which is a key factor in commitment to and continuation of married life [14, 15]. It is thus necessary to use psychological and behavioral strategies to moderate these types of defective behaviors. Various approaches to couples therapy and family therapy have been developed to mitigate relational conflicts and distress, reduce couples' maladjustment and violence, and promote their intimacy; these therapies are becoming increasingly known as major interventions to improve couples' mental health [16]. A highly effective therapy for this purpose is DVFCT [17]. This method of guided treatment is based on solution-focused brief therapy administered as Multi-group Couples (MC) and Single-Couple (SC) therapy. This treatment seeks to stop various forms of domestic violence. It also allows couples to continue their relationship while improving their positive experience and feelings by reducing relational anxiety, thus promoting their marital quality factors [18]. This therapy has an integrated treatment model that includes narrative methods and two main purposes: reducing all forms of violence and helping couples increase the quality of their marital relationship. In the first phase, the treatment focuses on training safety-enhancing skills, relaxation techniques, and negotiation style, while the second phase focuses on problem-solving methods as a conjoint treatment based on a solution-focused brief approach [19]. Mengo et al. [20] showed that marital psychological violence is inversely and significantly related to the dimensions of women's mental health and can be a negative predictor of mental health in married women. Aslani et al. [21] also reported that DVFCT helps mitigate marital violence, increase marital satisfaction, reduce marital distress, and promote psychological well-being.

Despite the applicability of this therapeutic-educational method, as well as the prevalence of domestic violence and couples reduced mental health, a review of the literature shows that little attention has been paid to this method and the important subject of domestic violence. Examining the effect of DVFCT on the mental health and intimacy of couples with marital conflict is one of the most important innovations of this study. Based on the mentioned materials, the present study aimed to investigate the effectiveness of DVFCT on marital violence, mental health, and sexual intimacy of couples with marital maladjustment in Ahvaz city.

Method

The present study was a single-case study with a non-concurrent multiple-baseline design. The statistical population comprised all volunteering couples with marital maladjustment visiting the counseling centers of Ahvaz (Iran) in 2021, of whom two couples (4 people) were purposively selected. In the current study, the adequacy of the sample size was determined based on the inclusion criteria and previous research [22]. For the initial identification of maladjusted couples, a call for DVFCT was made in the counseling centers. The inclusion criteria were the age range of 20-60 years, no psychological disorders (based on DSM-5 clinical interviews), no addiction (self-reported), having lived with the spouse for at least one year, the existence of physical violence in the relationship (self-reported), having at least a high-school diploma, and no intention to file a divorce. The exclusion criteria were receiving other therapies at the same time, and missing more than three sessions of the therapy. Written consent was received from the participants to participate in the research. Participants were also assured that their information will remain confidential. The present research has been approved by the ethics committee of Ahvaz Islamic Azad University. Also, clinical significance is used in this study. The data were analyzed visually and by using the Reliable Change Index (RCI) and the improvement percentage formula.

The tools used in this study were as follows:

The Symptom Checklist-90-Revised (SCL-90-R): This checklist was designed by Derogatis [23]. It examines nine symptomatic dimensions (somatization, obsessive-compulsive disorder, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) and three global measures (the Global Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST)). The respondents answer the items of this self-report measure on a five-point Likert scale, from not at all (0) to very high (4). The minimum score is 0 and the maximum score is

360. A higher score of the participant in this questionnaire indicates a lower mental health. Akhavan Abiri and Shairi [24] reported Cronbach's alpha coefficient of 0.88 for the Persian version of the questionnaire. In the present study, Cronbach's alpha coefficient was 0.86.

Couples' Sexual Intimacy Questionnaire: This 30-item questionnaire was developed by Botlani et al. [25]. Each item is scored on a four-point Likert (always, sometimes, rarely, never), scored from 1 to 4, respectively. The minimum score is 30 and the maximum score is 120. A higher score indicates more sexual intimacy. Botlani et al. [25] reported Cronbach's alpha coefficient of 0.81 for Persian version of the questionnaire. In the present study, Cronbach's alpha coefficient was 0.85.

Violence Against Women Questionnaire: This 32-item questionnaire was developed by Haj-Yahia [26]. It involves four factors: psychological violence (items 1 to 16), physical violence (items 17 to 27), sexual violence (items 28 to 30), and economic violence (items 31 and 32). The options (never, once, and twice or more) are scored 1, 2, and 3, respectively, and the final score ranges from 32 to 96. A higher score of the participant in this questionnaire indicates more marital violence. Sotoodeh Ghorbani et al. [27] reported Cronbach's alpha coefficient of 0.95 for the Persian version of this questionnaire. In the present study, Cronbach's alpha coefficient was 0.82.

Based on the responses to this call and couples' willingness to participate, and after explaining the inclusion and exclusion criteria, the eligible participants received Stith et al.'s [28] training protocol (Table 1). The intervention program was implemented by the first author who received specialized workshops on this intervention. The intervention program was carried out in the form of eighteen 60-minute sessions at the counseling center of Ahvaz Islamic Azad University.

Table 1. Summary of Domestic Violence-Focused Couples Treatment Sessions [28]

Session	Objective	Procedure
1: Examining the problem (a sex-segregated session)	Introduction, pretest	Introduction, discussing the general situation and family life history, individual meetings to investigate the reason for the visit
2: The foundation for DVFCT, defining the *miracle* (presence of both spouses)	Creating hope for the future	Posing the miracle question, creating a source of hope for the future
3: Violence against the intimate partner	Identifying various forms of violence (physical, psychological, emotional, social, financial, etc.)	Identifications of the types of violence
4: Safety planning and mindfulness	Training skills for dealing with violence	This session has two parts. Part 1: Training a type of meditation or mindfulness that helps clients with self-awareness and cognitive experiences Training a safety program for the clients and their families
5: Moderation and negotiation techniques	Monitoring-violence aggravating signs, allowing the partner to discuss issues, training problem-solving skills	A sex-segregated session is first held; the negotiated time-out technique is used; and the conjoint meetings are then held. Later in this session, Gottman's conflict resolution technique is implemented.
6: Substance abuse (This was omitted since it was an exclusion criterion in this study.)	The effects of substance use on life	The relationship imbalance due to substance abuse plot was drawn, and the clients were asked to discuss substance abuse and life (Johari window and planning for the future).
7-18: Stage 2: Conjoint treatment	Conjoint treatment	This stage involved conjoint treatment with both spouses. Clients first signed a non-violence agreement. The first step involved individual control. Each spouse met separately with the therapist and were asked about his/her success or recurrence of violence in the past week. They would enter the state of mindfulness if there were no problems (10 minutes of mindfulness). During the conjoint session, in case of any factor (fear, anger, anxiety, violence) that might endanger the clients 'security, the session would be halted. Then, the appropriate first-stage skill would be administered to both spouses according to the type of problem.

Results

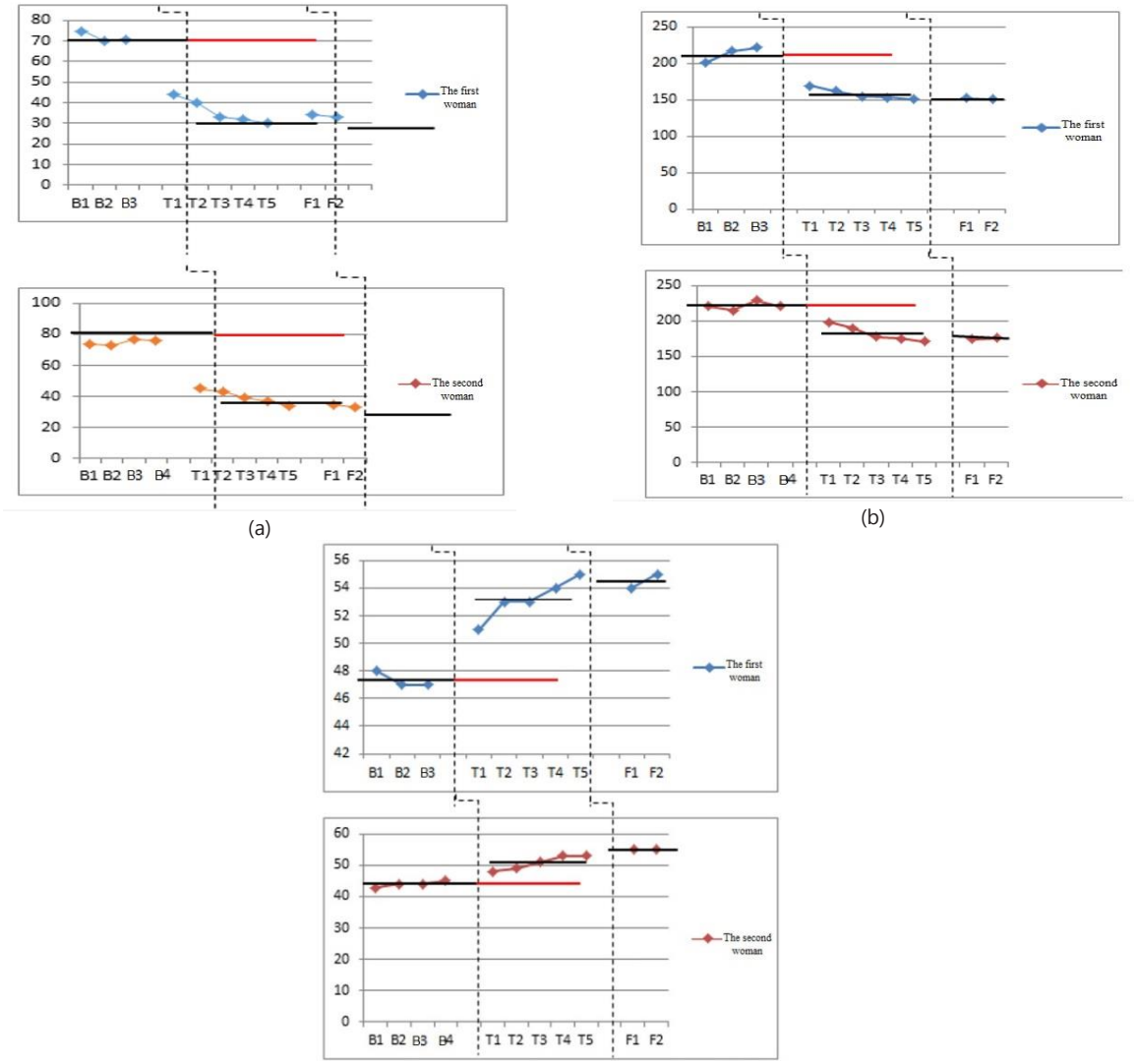
The means and Standard Deviation (SD) age and duration of marriage of participants were 36.25 (7.41) and 8.12 (3.38) respectively. Table 2 reveals the trend of variation in the scores of the constructs of marital violence, mental health, and sexual intimacy at the baseline, intervention, and follow-up stages for both men and women receiving the DVFCT. The mean and levels of scores of marital violence, mental health, and sexual intimacy improved during the treatment and follow-up stages compared to the baseline. Based on the Conservative Dual-Criterion (CDC), for all the clients in the treatment stage, all the points of the plotted data were above the predictive line and trend of variations, suggesting the significant effect of the independent variable on the dependent variable.

The mean and level of scores of the studied

constructs improved in the treatment and follow-up stages compared to the baseline, and the value of the RCI was significant (Figure 1 and 2). Therefore, the DVFCT was successful in the treatment and follow-up stages (based on clinical significance). Overall, the findings suggest the success of this therapy in improving all the examined constructs.

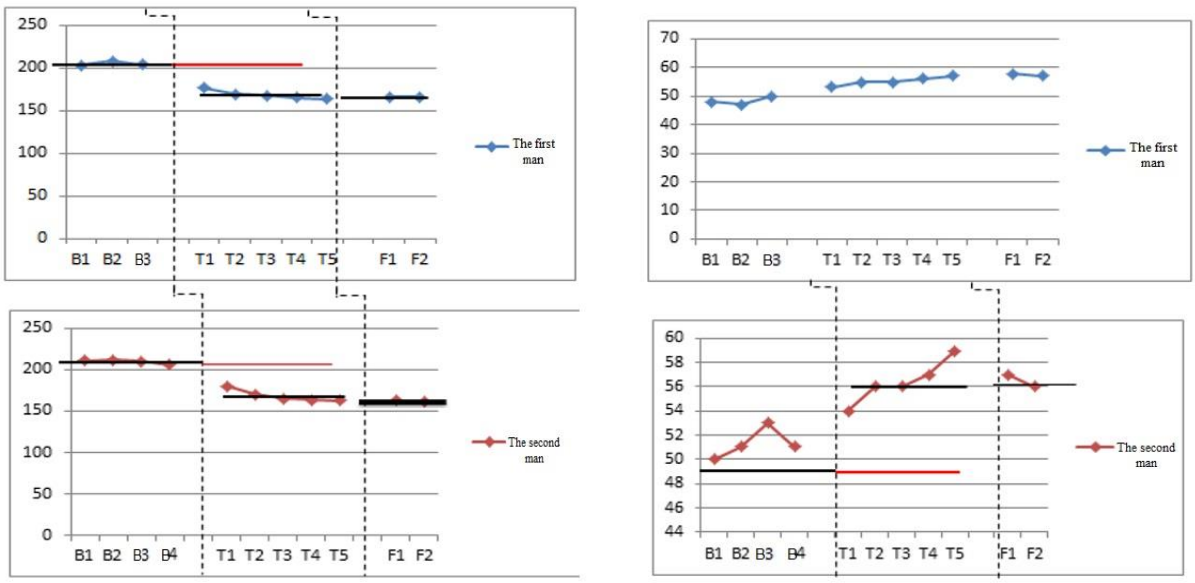
Table 2. Trend of Changing the Treatment Phases on Marital Violence, Mental Health, and Sexual Intimacy

Variable	Marital violence		Mental health				Sexual intimacy			
Treatment phases	The first woman	The second woman	The first woman	The second woman	The first man	The second man	The first woman	The second woman	The first man	The second man
First baseline	75	74	201	220	209	212	48	43	48	50
Second baseline	70	73	217	215	204	210	47	44	47	51
Third baseline	71	77	222	229	-	206	47	44	50	53
Fourth baseline	-	76	-	221	176	180	-	45	-	51
First session	44	45	170	199	170	170	51	48	53	54
Second session	40	43	162	190	168	168	53	49	55	56
Third session	33	39	155	178	165	165	53	51	55	57
Fourth session	32	37	153	175	164	164	54	53	56	57
Fifth session	30	34	150	171	166	166	55	53	57	59
First follow-up	34	33	152	150	162	161	54	55	58	57
Second follow-up	35	33	176	174	203	211	55	55	57	56
Reliable change index (treatment)	25.85	25.28	14.33	10.01	23.39	26.21	5.01	5.81	5.58	4.34
Reliable change index (follow-up)	27.50	29.28	16.14	11.97	25.05	30.73	6.12	9.40	7.45	4.26



(a) (b) (c)

Figure 1. The trend of marital violence (a), mental health (b), and sexual intimacy (c) scores in the women at baseline, treatment, and follow-up phases. Note. Reference: Results of the present study.



(a) (b)

Figure 2. The trend of mental health (a) and sexual intimacy (b) scores in the men at baseline, treatment, and follow-up phases. Note. Reference: Results of the present study.

Discussion

This study aimed to investigate the effectiveness of DVFCT on marital violence, mental health, and sexual intimacy of couples with marital maladjustment in Ahvaz (Iran). The findings revealed that the DVFCT brought about significant and positive changes in marital violence, mental health, and sexual intimacy of all four couples, and these improvements persisted through the follow-up stages. The results are consistent with the results of previous studies [18, 21].

DVFCT seeks to stop all kinds of violence in the relationship. Although it is important to end physical violence, this approach helps identify and eliminate other forms of violence as well. This approach considers methods for controlling violence or psychological violence against partners and helps clients eliminate different forms of violence [17]. It also helps some partners consider continuing their relationship. If the spouses stay together or separate without violence, the treatment is considered to be effective. After this treatment, especially in the first stage where skills are taught (time-out, healthy conversation, conflict resolution, problem-solving), physical violence is the first type of violence eliminated from the relationship, following which other types of violence also subside [18]. What keeps people impudent is that they ignore their role in the problem, and what sets them free is viewing their role in the patterns that hold them together. The concept of interdependence is significant in this therapy; based on this idea, although the violent person is responsible for his/her actions, disrupting offensive repetitive behavioral patterns in the couples system is a powerful tool for managing problems. Maladjusted couples have serious problems with accepting responsibility at the beginning of the treatment, especially the female victim who holds her husband responsible for beating her [28]. When tasks are assigned to them during the therapy, they may resist or get angry. The secondary purpose of this treatment is to promote a positive experience and feeling in the partners. If a couple decides to continue their relationship, this therapy helps them develop a positive experience and feeling [3].

In violent relationships, couples become so involved in conflicts and enter a vicious cycle of behaviors that they spend all their energy on finding the other party's weaknesses and flaws. These couples are highly critical and dissatisfied, and their criticism is often harsh. Due to the extensive criticism, the other party feels threatened, quickly becomes defensive, and constantly tries to justify his/her behavior or retaliate, thereby taking his/her revenge with more severe criticism. In this case, under no circumstances can these behaviors become more positive or a positive feeling be created towards the other party. In particular, victims may have many negative feelings, and when they are asked to write down their spouse's positive points, they may be surprised. Another goal of this program is to increase the responsibility of each party for his/her behavior, which is done throughout the program. Although we systematically think about the type of violence that should be treated in this program (i.e., couples' situational violence), this therapy helps each person accept his/her role in ending the violence and improving the relationship [19].

Participating in this treatment also allows each party to acquire effective techniques for communication, problem-solving, conflict resolution, and relaxation, which ultimately resolves conflicts between couples. These skills lead to better communication with the spouse and help couples experience a greater degree of happiness and satisfaction in their marital relationship. In fact, this therapy helps people to effectively and efficiently deal with their familial, occupational, educational, and social settings. DVFCT puts a special emphasis on learning sexual violence control skills. Women significantly acquire violence control techniques, including time-out, healthy conversation, conflict resolution, and problem-solving

against the sexual partner. After the sessions, the level of violence, especially sexual violence from the partner, is markedly reduced, and couples gradually learn to experience non-violent relationships [28]. This improvement in relationships will increase the couples' level of health and alleviate violent behaviors.

This study was conducted on a small sample taken from the population, which can limit the generalizability of the results. Therefore, the results may not be generalized to other cultures. In the present study, the use of a single-case experimental design limits the generalization of the results. It is recommended to conduct a similar study on larger samples and in other cultural settings. Moreover, for future research, it is suggested to do a more detailed evaluation of the DVFCT approach by repeating this research using other experimental designs including pre-test-post-test with the control group.

Conclusion

As a result, DVFCT is a suitable approach in reducing marital violence and improving the mental health and sexual intimacy of couples with marital maladjustment. According to the findings of this study, couple therapists and counselors can improve the mental health and sexual intimacy of couples with marital maladjustment through domestic violence-focused couple therapy.

Conflict of Interest

The authors declare that they have no conflicts of interest.

Ethical Approval

The Ethics Review Board of Islamic Azad University, Ahvaz branch, approved the present study with the following number: IR.IAU.AHVAZ.REC.1400.021.

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