KMAN PUBLISHING INSTITUTE
Journal Website

Article history:
Received 12 August 2025
Revised 20 November 2025
Accepted 27 November 2025
Initial Published 29 November 2025
Final Publication 01 January 2026

KMAN Counseling & Psychology Nexus

Volume 4, pp 1-12

E-ISSN: 3041-9026

Comparison of the Effectiveness of Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy on Dysfunctional Beliefs in Infertile Couples

Samaneh. Haji Abbasi[1], Majid. Saffarinia[2*], Ali Mohammad. Rezaie[1]

[1] Department of Psychology, Arc.C., Islamic Azad University, Arsanjan, Iran
[2] Department of Psychology, Payame Noor University, Tehran, Iran

*** Corresponding author email address**: m.saffarinia@pnu.ac.ir

A r t i c l e I n f o

Article type:
Original Research
Section:
Family and Couple Therapy

How to cite this article:
Haji Abbasi, S., Saffarinia, M., & Rezaie, A. M. (2026). Comparison of the Effectiveness of Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy on Dysfunctional Beliefs in Infertile Couples. *KMAN Conseling and Psychology Nexus, 4*, 1-12.
http://doi.org/10.61838/kman.fct.psynexus.4815

A B S T R A C T

This study aimed to compare the effectiveness of Acceptance and Commitment–based Couple Therapy (ACT-CT) and Integrative Couple Therapy (IBCT) in reducing dysfunctional beliefs among infertile couples. This quasi-experimental study employed a pretest–posttest design with a control group and a three-month follow-up. The statistical population included infertile couples who were referred to the infertility center of Karaj University of Medical Sciences in 2023 and met the diagnostic criteria for infertility. Using purposive sampling, 45 couples were selected based on inclusion and exclusion criteria and were randomly assigned into three groups: ACT-CT (n = 15), IBCT (n = 15), and control (n = 15). The Dysfunctional Beliefs Questionnaire (Eidelson & Epstein, 1981) was administered at pretest, posttest, and follow-up. The ACT-CT and IBCT groups received twelve 90-minute sessions over three months, while the control group received no intervention. Due to attrition, the final sample consisted of 14 ACT-CT couples, 13 IBCT couples, and 15 control couples. Data were analyzed using repeated-measures ANOVA and multivariate tests. Results showed significant time, group, and group × time interaction effects for all components of dysfunctional beliefs ($p < .05$). Comparative analyses indicated that ACT-CT produced significantly greater reductions than IBCT in beliefs about the destructiveness of conflict ($p = .030$), partner unchangeability ($p = .019$), and total dysfunctional belief scores ($p = .001$). Bonferroni post-hoc tests confirmed significant improvements from pretest to posttest and follow-up in both intervention groups, with no meaningful changes in the control group. Both ACT-CT and IBCT effectively reduced dysfunctional beliefs in infertile couples; however, ACT-CT demonstrated superior effectiveness in modifying key maladaptive cognitive components.

Keywords: *Acceptance and Commitment Couple Therapy, Integrative Approach, Dysfunctional Beliefs, Infertile Couples*

1. Introduction

Infertility is widely recognized as one of the most stressful and life-altering conditions couples may encounter, affecting their psychological wellbeing, relationship quality, and family functioning. The global prevalence of infertility continues to rise, affecting an estimated 8–12% of couples worldwide, and producing extensive emotional, relational, and existential consequences (Obeagu et al., 2023). The psychological burden of infertility is particularly pronounced among couples who undergo medical treatments or experience prolonged unsuccessful attempts at conception, often leading to heightened levels of anxiety, depression, emotional disconnection, and marital strain (Pásztor et al., 2019). Research has shown that infertility undermines a couple's sense of identity, future planning, gender roles, and relational cohesion, making psychological support a critical component of infertility care (Pasch & Sullivan, 2017). The chronic stress associated with infertility also increases conflict sensitivity, reduces emotional availability, and amplifies maladaptive cognitive and behavioral patterns within marital relationships (Sedghi et al., 2019). Given these realities, psychological interventions specifically tailored to infertile couples have become essential for helping them navigate relational distress, strengthen adaptive functioning, and enhance emotional resilience.

Infertility not only affects psychological health but also has significant medical and environmental correlates. Emerging evidence links environmental toxins and persistent organic pollutants (POPs) to adverse reproductive outcomes and lower success rates in fertility treatments (Lefebvre et al., 2021). Simultaneously, population-based findings indicate that infertility may be associated with increased long-term health risks, including premature mortality among women (Wang et al., 2022). These findings illustrate how infertility is both a biopsychosocial and relational challenge that requires comprehensive intervention strategies. The emotional and relational toll is exacerbated by negative appraisals of infertility, rigid cognitive interpretations, and catastrophic thinking, which have been shown to predict higher levels of distress (Yoshiko & Hiroya, 2022). For this reason, cognitive-relational responses to infertility play a mediating role in couples' adjustment. Infertile couples often struggle with dysfunctional beliefs, such as mind-reading expectations, beliefs about a partner's unchangeability, and maladaptive assumptions about gender roles—each of which increases conflict severity and reduces marital satisfaction (Barraca et al., 2024). These cognitive distortions have been previously identified as robust predictors of marital distress (Beck, 1978), reinforcing the need for interventions that can modify entrenched beliefs and improve relational functioning.

Psychotherapeutic intervention for infertile couples requires theoretical models capable of addressing deeply ingrained relational and cognitive patterns. Systemic approaches, such as Bowen's family systems theory, highlight how multigenerational patterns and emotional cut-off influence couples' emotional processes during infertility crises (Bowen, 2003). From a systemic perspective, infertility may activate unresolved family-of-origin trauma, intensify fusion or distance patterns, and reduce differentiation of self (Çinar, 2025). These systemic disruptions compromise couples' coping strategies and interfere with effective communication. However, while systemic approaches offer foundational insights, contemporary couples therapy increasingly emphasizes integrative and process-based models that combine behavioral, emotional, and cognitive change mechanisms. Integrative Behavioral Couple Therapy (IBCT), for example, has become one of the leading empirically supported interventions in couple therapy practice (Christensen & Jacobson, 1998). IBCT integrates acceptance and change strategies, helping partners reduce polarization and build greater emotional intimacy, while addressing entrenched interaction cycles (Briggs et al., 2015). Evidence shows that IBCT produces significant improvements in relationship satisfaction, communication, mutual support, and adaptive coping (Lebow, 2015). Its emphasis on acceptance makes IBCT particularly suitable for couples confronting chronic stressors such as infertility.

IBCT conceptualizes marital problems as patterns jointly regulated by both partners, and thus prioritizes acceptance, emotional neutrality, and empathic understanding before change-focused interventions are introduced (Snyder & Balderrama-durbin, 2022). Its clinical procedures include case formulation, emotional validation, unified detachment, and tolerance building, which together help partners understand their conflict cycles from a non-blaming stance (Barraca et al., 2021). Previous research has shown that IBCT produces positive relational outcomes in couples experiencing emotional disorders, anxiety, marital burnout, and obsessive relational dynamics (Sorush et al., 2021). Additional work highlights the effectiveness of IBCT for infertile couples specifically, including improvements in infertility self-efficacy, dyadic adjustment, and sexual

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E-ISSN: 3041-9026

satisfaction (Vazirnia et al., 2021a, 2021b). IBCT has also been shown to reduce marital dissatisfaction and psychological distress in couples dealing with chronic illness, demonstrating its adaptability across diverse clinical populations (Ahmadzadeh et al., 2019). More recently, researchers have underlined the importance of integrating cognitive components within IBCT to address dysfunctional attitudes, particularly among women with marital distress (Taghavi Sureh Bargh & Mahdizadeh, 2022). Taken together, these findings provide strong support for IBCT as an effective modality for modifying dysfunctional relationship beliefs.

Alongside IBCT, Acceptance and Commitment Therapy (ACT) for couples has emerged as a powerful third-wave behavioral approach that targets psychological flexibility, experiential acceptance, and values-based action (Walser & O'Connell, 2023). ACT views relational distress as exacerbated by experiential avoidance, cognitive fusion, and disconnection from personally meaningful values (Peterson et al., 2009). By enhancing psychological flexibility, ACT helps couples respond more constructively to infertility-related distress, regulate emotions more effectively, and reduce rigid patterns of interaction (Rabiei et al., 2023). ACT-based interventions emphasize mindfulness, acceptance of internal experiences, and the cultivation of value-driven relational behaviors. Through techniques such as cognitive defusion, present-moment awareness, and committed action, partners become better equipped to tolerate distress, reduce conflict escalation, and enhance emotional closeness (Barraca et al., 2024). Recent clinical trials show that ACT significantly improves emotional functioning, decreases marital conflict, and increases marital satisfaction among distressed couples (Rajabi et al., 2013). Moreover, ACT has demonstrated strong effectiveness in infertile couples by enhancing cognitive empathy, strengthening attachment bonds, and improving sexual satisfaction (Ahmadi, 2025). Further research indicates that ACT is particularly effective for reducing irrational beliefs, improving differentiation of self, and mitigating the psychological impact of infertility (Hosseinpanahi & Mirkhafvand, 2020; Mousavi Haghighi et al., 2022). Studies also highlight ACT's superior outcomes relative to other modalities when addressing worry, marital adjustment, and infertility-related cognitive distortions (Sedghi et al., 2019). Because ACT directly targets dysfunctional cognitive patterns, it is especially well-suited for addressing the rigid and maladaptive relationship beliefs common among infertile couples (Deyhimi et al., 2019).

Comparative studies between ACT and IBCT also demonstrate nuanced distinctions between the two models. Meta-analytic evidence suggests that ACT and IBCT both improve marital functioning but may differ in the mechanisms through which they influence relational outcomes (Keybollahi et al., 2022). ACT primarily alters cognitive-emotional processes by increasing psychological flexibility, whereas IBCT modifies interactional patterns through acceptance and behavioral change strategies. In couples dealing with infertility, these mechanisms may operate differently depending on the severity of cognitive fusion, emotional reactivity, and interactional rigidity. Research comparing ACT and IBCT has found that ACT may produce greater reductions in worry and cognitive rigidity, while IBCT may exert stronger effects on relational communication and emotional attunement (Mokhtari Sorkhani et al., 2021). Nevertheless, both approaches have been validated as effective for enhancing relational functioning under chronic stress. In acute or persistent infertility-related distress, ACT has shown particular promise due to its ability to reduce experiential avoidance—a key predictor of marital dissatisfaction in infertile couples (Çinar, 2025). Likewise, IBCT's emphasis on acceptance may help couples reinterpret infertility-related challenges in less reactive ways, improving their interpersonal problem-solving and cooperation (Snyder et al., 2019). Despite these benefits, many couples continue to struggle with dysfunctional beliefs that persist even after therapy, indicating the need to better understand which therapeutic model is more effective in altering these cognitive patterns.

Dysfunctional beliefs in couples—including beliefs about conflict, mind-reading expectations, partner unchangeability, gender-role rigidity, and sexual perfectionism—play central roles in the persistence of marital distress (Yazar & Tolan, 2021). These beliefs have strong roots in cognitive-behavioral theory (Beck, 1978) and are consistently linked to poor marital outcomes such as burnout, dissatisfaction, and conflict escalation. Within the context of infertility, dysfunctional beliefs are amplified by high emotional arousal and chronic uncertainty (Ahmadi, 2025). Thus, infertility functions as both a catalyst and magnifier of cognitive distortions. Prior studies confirm that psychological interventions can significantly modify these beliefs; however, the relative effectiveness of ACT versus IBCT remains underexplored among infertile couples. Evidence suggests that ACT may produce stronger changes in maladaptive thinking because it directly targets cognitive fusion and experiential avoidance (Rabiei et al., 2023), while

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IBCT may reduce dysfunctional beliefs indirectly via acceptance and empathy building (Christensen & Jacobson, 1998). The lack of consensus in the literature highlights a significant research gap regarding which modality is more effective in targeting dysfunctional beliefs specifically within infertile populations.

Given the increasing psychological vulnerability of infertile couples and the centrality of dysfunctional beliefs in shaping their relational experiences, rigorous comparative research between ACT and IBCT is needed to guide clinical decision-making and enhance treatment outcomes. Although ACT and IBCT share common behavioral foundations, their distinct mechanisms suggest that they may differentially impact maladaptive cognitive patterns. Furthermore, infertility presents a unique relational context that requires targeted interventions for cognitive restructuring and acceptance-building processes. Therefore, this study seeks to provide empirical clarity by comparing the effectiveness of ACT and IBCT in altering dysfunctional beliefs among infertile couples.

The aim of the present study is to compare the effectiveness of Acceptance and Commitment–based Couple Therapy and Integrative Couple Therapy on dysfunctional relationship beliefs in infertile couples.

2. Methods and Materials

2.1. Study Design and Participants

The research design, based on the study objectives and hypotheses, was a quasi-experimental design with a pretest–posttest and follow-up structure including a control group, in which the effects of the independent variables (Acceptance and Commitment–based Couple Therapy and Integrative Couple Therapy) on the dependent variable (dysfunctional beliefs) were examined. The statistical population consisted of all infertile couples who referred to the Infertility Center of Karaj University of Medical Sciences with a definitive diagnosis of infertility in 2023. A purposive sampling method was used. Based on the study's inclusion and exclusion criteria, 45 couples were selected through purposive sampling and were randomly assigned to two experimental groups and one control group (15 couples in the first experimental group, 15 couples in the second experimental group, and 15 couples in the control group).

After selecting the sample, the Dysfunctional Beliefs Questionnaire was completed in the pretest phase by participants in the first experimental group, the second experimental group, and the control group. In the next phase, Acceptance and Commitment–based Couple Therapy was administered to the first experimental group, and Integrative Couple Therapy was administered to the second experimental group. The control group remained on a waiting list and received no psychological intervention until the posttest phase. At the end of the intervention program, the Dysfunctional Beliefs Questionnaire was again completed by participants in both experimental groups and the control group during the posttest phase. To assess the stability of intervention effects, a follow-up measurement was conducted three months later.

After completing the research procedures, and based on the study's exclusion criteria, one couple was removed from the Acceptance and Commitment–based Couple Therapy group, and data from 14 couples were analyzed. In addition, two couples from the Integrative Couple Therapy group were excluded due to missing more than two sessions, and data from 13 couples were analyzed; however, all 15 couples in the control group participated in all stages.

The inclusion criteria were: (a) diagnosis of infertility after at least one year of attempting to conceive by a gynecologist or urologist; (b) at least two years of marital life; (c) the couple's willingness to voluntarily participate in therapy sessions and complete the questionnaires at all three stages (pretest, posttest, and follow-up); (d) no history of participation in other individual or couple psychotherapy programs during the past six months; (e) no severe psychotic disorder, addiction, or chronic physical illness that would interfere with regular session attendance (based on self-report and preliminary interview); and (f) sufficient reading and writing literacy to understand and respond to research instruments.

The exclusion criteria were: absence from more than two therapy sessions; desire to withdraw from the study at any stage of the intervention or assessment process; occurrence of new family, physical, or psychological crises (such as hospitalization, divorce, or bereavement) during the research period; and inaccurate or incomplete questionnaire responses.

2.2. Measures

This self-report instrument was developed in 1981 by Eidelson and Epstein to assess dysfunctional beliefs in marital relationships. The inventory consists of 40 items with five subscales: belief in the destructiveness of conflict, belief in the partner's unchangeability, belief in mind-reading expectations, belief in sexual perfectionism, and

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E-ISSN: 3041-9026

belief in gender differences. Items are rated on a 6-point Likert scale (from "completely false" = 0 to "completely true" = 5). Items 1, 6, 11, 16, 21, 26, 31, and 36 measure belief in the destructiveness of conflict; items 3, 8, 13, 18, 23, 28, 33, and 38 measure belief in the partner's unchangeability; items 2, 7, 12, 17, 27, 32, and 37 measure belief in mind-reading expectations; items 4, 9, 14, 19, 24, 29, 34, and 39 measure belief in sexual perfectionism; and items 5, 10, 15, 20, 25, 30, 35, and 40 measure belief in gender differences. Higher scores indicate stronger dysfunctional and irrational beliefs in marital relationships. Cronbach's alpha values for the subscales range from .72 to .82, and .86 for the total scale. The developers also showed that scores on this inventory positively correlate with the General Beliefs Questionnaire developed by Jones (1968). The Persian version of the instrument was prepared by Mazaheri and Pour-Etemad (2001) using a translation and back-translation procedure, with a Cronbach's alpha of .75. In the study by Akhavan-Gholami and Hayati (2019), Cronbach's alpha for the instrument was .72. In the present study, Cronbach's alpha was calculated as .79.

2.3. Interventions

Acceptance and Commitment–based Couple Therapy was delivered to the first experimental group across twelve 90-minute sessions over three months, following the Peterson and Eifert (2011) protocol adapted for infertile couples. The program began with establishing therapeutic rapport and clarifying expectations, during which the therapist introduced the structure, goals, and rules of the sessions and asked partners to write their expectations and goals. The second session focused on problem conceptualization through exploring how conflicts develop, using the "hole and shovel" metaphor to highlight maladaptive interaction patterns, and asking couples to identify situations where they experienced a "hole" and used an unhelpful "shovel." In the third session, couples learned about choice and commitment in relationships, practicing openness, presence, and willingness for healthy interaction supported by a daily nonjudgmental listening exercise. Sessions four to eight targeted specific marital problems: Session four introduced the "mind fence" metaphor to address intrusive thoughts and trained cognitive defusion through observing thoughts without judgment; session five focused on modifying dysfunctional expectations using the "poison versus antidote" metaphor through acceptance and cognitive flexibility; session six guided partners in clarifying individual and shared values and designing value-consistent behavioral steps; session seven addressed emotional reconnection through recognizing "poison: disconnection" and applying "antidote: becoming one with the partner," using empathic dialogue without defensiveness; session eight addressed emotional avoidance by teaching acceptance of difficult emotions through the "poison: emotional avoidance" and "antidote: willingness to experience discomfort" framework. Session nine reinforced marital values through reviewing shared values, identifying obstacles, choosing one value to operationalize, and planning a value-based joint activity. Session ten focused on internal barriers such as negative beliefs, fears, and self-talk, training partners to defuse from them and record situations in which internal barriers impeded value-driven actions. Session eleven targeted external (environmental and interpersonal) barriers by teaching problem-solving steps and requiring couples to implement and report on a real-life solution. The final session emphasized consolidation by reviewing all previous concepts, introducing the "psychological fog" metaphor (including internal "shoulds," "if-onlys," and rigid demands), and developing an individualized plan for maintaining and strengthening value-based behaviors beyond therapy.

Integrative Couple Therapy was delivered to the second experimental group in twelve 90-minute sessions over three months based on Christensen and Jacobson's (1998) protocol. The first session focused on introductions and establishing the therapeutic framework, presenting the rationale of couples therapy and defining communication rules. In the second session, the therapist conducted individual meetings with each partner to ensure confidentiality, assess maladaptive cognitions and emotional avoidance patterns, and explore the history of the marital relationship. The third session involved providing feedback to the couple and generating an initial case formulation identifying major relational themes and problem areas. Session four emphasized identifying relational strengths, examining the congruence between the therapist's formulation and the couple's perceptions, and building consensus on therapeutic goals. The fifth session involved analyzing dysfunctional interaction patterns and introducing interventions to interrupt, modify, or redirect problematic exchanges. The sixth session focused on emotion-based interventions to enhance emotional awareness, foster empathic listening, and strengthen emotional sensitivity during interactions. Session seven involved reviewing therapeutic progress, revising the case formulation based on

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emerging information, and adjusting goals accordingly. The eighth session taught acceptance strategies and emotional distancing techniques to help partners reduce emotional reactivity during conflict. In the ninth session, couples practiced modified behavioral exchanges, communication skills, and positive interaction patterns during in-session exercises. Session ten emphasized increasing distress tolerance and self-care, including practicing negative behaviors within a controlled therapeutic environment and identifying individualized self-care strategies. The eleventh session focused on generalization by practicing "behavioral rehearsals" of negative interactions at home to increase awareness and tolerance of each partner's reactions in real-life contexts. The twelfth and final session emphasized self-reflection, reviewing emotional and behavioral changes achieved throughout therapy, summarizing the entire therapeutic process, and collaboratively developing a plan for maintaining therapeutic gains in the future.

2.4. Data analysis

Data analysis was performed using repeated-measures analysis of variance in SPSS-26.

3. Findings and Results

Table 1 presents the mean (standard deviation) of the components of dysfunctional beliefs (belief in the destructiveness of conflict, mind-reading expectation, belief in the partner's unchangeability, sexual perfectionism, and beliefs about gender differences) among participants in the three study groups across the pretest, posttest, and follow-up phases.

Table 1

Mean and Standard Deviation of Components and Total Score of Dysfunctional Beliefs in Pretest, Posttest, and Follow-up

Variable	Component	Group	Pretest	Posttest	Follow-up
Dysfunctional Beliefs	Destructiveness of Conflict	Acceptance and Commitment	25.96 ± 4.94	18.89 ± 3.48	19.60 ± 3.58
		Integrative Couple Therapy	27.11 ± 5.21	21.03 ± 2.83	21.15 ± 3.33
		Control Group	26.70 ± 4.25	24.73 ± 3.56	25.87 ± 4.65
	Mind-reading Expectation	Acceptance and Commitment	27.46 ± 6.14	20.11 ± 3.86	21.45 ± 3.81
		Integrative Couple Therapy	25.54 ± 4.57	21.42 ± 4.53	22.04 ± 3.97
		Control Group	26.23 ± 4.91	25.20 ± 4.21	25.53 ± 3.43
	Partner's Unchangeability	Acceptance and Commitment	28.50 ± 5.67	20.32 ± 3.58	20.93 ± 3.63
		Integrative Couple Therapy	29.34 ± 5.96	23.54 ± 4.36	23.34 ± 4.35
		Control Group	30.28 ± 4.62	28.23 ± 5.00	29.37 ± 4.63
	Sexual Perfectionism	Acceptance and Commitment	19.61 ± 3.73	15.75 ± 2.96	16.86 ± 3.35
		Integrative Couple Therapy	20.92 ± 3.71	16.03 ± 3.18	16.65 ± 2.99
		Control Group	19.30 ± 3.90	20.13 ± 4.15	19.53 ± 3.73
	Beliefs About Gender Differences	Acceptance and Commitment	20.29 ± 3.91	16.43 ± 2.60	16.32 ± 2.58
		Integrative Couple Therapy	21.81 ± 3.32	17.42 ± 2.83	17.27 ± 2.69
		Control Group	21.10 ± 4.06	19.83 ± 3.35	20.23 ± 2.86
	Total Score	Acceptance and Commitment	121.82 ± 12.70	91.50 ± 8.52	95.18 ± 9.38
		Integrative Couple Therapy	124.73 ± 11.89	89.46 ± 8.69	100.46 ± 7.83
		Control Group	123.60 ± 12.33	118.13 ± 8.67	120.53 ± 9.07

Table 1 shows that in both experimental groups, the mean scores of the components and the total score of dysfunctional beliefs decreased in the posttest and follow-up phases. In contrast, no similar changes were observed in the control group.

To analyze the data, the assumptions of repeated-measures ANOVA—including normal distribution, homogeneity of error variances, homogeneity of covariance matrices of dependent variables, and sphericity—were evaluated.

After assessing these assumptions and ensuring that they were met, the hypotheses were tested using repeated-measures ANOVA. Table 2 presents the results of the multivariate analysis comparing the effects of Acceptance and Commitment–based Couple Therapy and Integrative Couple Therapy on the components and total score of dysfunctional beliefs.

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Table 2

Results of Multivariate Analysis (MANOVA) for Evaluating the Effect of Independent Variables on Dysfunctional Beliefs

Dependent Variable	Wilks' Lambda	F	df	P	η^2	Power
Destructiveness of Conflict	.815	4.30	4, 160	.002	.097	.924
Mind-reading Expectation	.828	3.95	4, 160	.004	.090	.899
Partner's Unchangeability	.817	4.26	4, 160	.003	.096	.921
Sexual Perfectionism	.790	4.99	4, 160	.001	.111	.959
Beliefs About Gender Differences	.882	2.60	4, 160	.039	.061	.720
Total Score	.605	11.43	4, 160	.001	.222	1.00

Table 2 indicates that the effects of the independent variables on all components and on the total score of dysfunctional beliefs were statistically significant.

Table 3 presents the results of repeated-measures ANOVA explaining the effects of Acceptance and Commitment–based Couple Therapy and Integrative Couple Therapy on the components and total score of dysfunctional beliefs.

Table 3

Results of Repeated-Measures ANOVA for Explaining the Effect of Independent Variables on Dysfunctional Beliefs

Variable	Effects	Sum of Squares	Error Sum of Squares	F	P	η^2
Destructiveness of Conflict	Group Effect	814.67	1231.60	26.79	.001	.398
	Time Effect	804.47	1290.78	50.48	.001	.384
	Group × Time Interaction	330.40	2539.35	5.27	.001	.115
Mind-reading Expectation	Group Effect	406.12	1903.98	8.64	.001	.176
	Time Effect	483.87	1823.40	21.50	.001	.210
	Group × Time Interaction	334.35	2890.03	4.69	.001	.104
Partner's Unchangeability	Group Effect	1640.89	1946.85	34.14	.001	.457
	Time Effect	976.47	1720.36	46.07	.001	.363
	Group × Time Interaction	425.76	3372.97	5.11	.001	.112
Sexual Perfectionism	Group Effect	246.29	1118.61	8.92	.001	.180
	Time Effect	214.16	959.87	18.07	.001	.182
	Group × Time Interaction	291.65	1962.67	6.02	.001	.129
Beliefs About Gender Differences	Group Effect	322.45	903.88	14.45	.001	.263
	Time Effect	408.27	898.45	36.81	.001	.312
	Group × Time Interaction	129.74	1572.54	3.34	.012	.076
Total Score	Group Effect	14788.65	8966.40	66.80	.001	.623
	Time Effect	13567.71	10249.12	107.23	.001	.570
	Group × Time Interaction	6620.27	15662.76	17.12	.001	.297

Table 3 indicates that, in addition to the main effects of group and time, the group × time interaction effect was significant for the components of belief in the destructiveness of conflict (η^2 = .115, p = .001, F = 5.27), mind-reading expectation (η^2 = .104, p = .001, F = 4.69), belief in the partner's unchangeability (η^2 = .112, p = .001, F = 5.11), sexual perfectionism (η^2 = .129, p = .001, F = 6.02), beliefs about gender differences (η^2 = .076, p = .012, F = 3.34), and the total score of dysfunctional beliefs (η^2 = .297, p = .001, F = 17.12). These findings indicate that the implementation of the independent variables significantly influenced the components and total score of dysfunctional beliefs. Table 4 presents the Bonferroni post-hoc test results for pairwise comparisons of group and time effects on dysfunctional beliefs.

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Table 4

Results of Bonferroni Post-Hoc Test for Pairwise Comparisons of Group and Time Effects on Dysfunctional Beliefs

Variable	Comparison	Mean Difference	Standard Error	p-value
Destructiveness of Conflict	Pretest – Posttest	5.04	0.67	.001
	Pretest – Follow-up	4.38	0.62	.001
	Posttest – Follow-up	−0.65	0.54	.696
Mind-reading Expectation	Pretest – Posttest	4.17	0.65	.001
	Pretest – Follow-up	3.40	0.73	.001
	Posttest – Follow-up	−0.77	0.57	.542
Partner's Unchangeability	Pretest – Posttest	5.35	0.76	.001
	Pretest – Follow-up	4.84	0.71	.001
	Posttest – Follow-up	−0.52	0.64	1.00
Sexual Perfectionism	Pretest – Posttest	2.64	0.57	.001
	Pretest – Follow-up	2.26	0.53	.001
	Posttest – Follow-up	−0.37	0.51	1.00
Beliefs About Gender Differences	Pretest – Posttest	3.17	0.50	.001
	Pretest – Follow-up	3.12	0.52	.001
	Posttest – Follow-up	−0.05	0.42	1.00
Total Score	Pretest – Posttest	20.36	1.56	.001
	Pretest – Follow-up	18.00	1.74	.001
	Posttest – Follow-up	−2.36	1.22	.168
Destructiveness of Conflict	Acceptance & Commitment – Integrative	−1.61	0.61	.030
	Acceptance & Commitment – Control	−4.28	0.59	.001
	Integrative – Control	−2.66	0.60	.001
Mind-reading Expectation	Acceptance & Commitment – Integrative	0.01	0.76	1.00
	Acceptance & Commitment – Control	−2.64	0.74	.001
	Integrative – Control	−2.66	0.75	.001
Partner's Unchangeability	Acceptance & Commitment – Integrative	−2.16	0.77	.019
	Acceptance & Commitment – Control	−6.05	0.74	.001
	Integrative – Control	−3.89	0.76	.001
Sexual Perfectionism	Acceptance & Commitment – Integrative	−0.47	0.58	1.00
	Acceptance & Commitment – Control	−2.25	0.56	.001
	Integrative – Control	−1.78	0.58	.008
Beliefs About Gender Differences	Acceptance & Commitment – Integrative	−1.16	0.53	.092
	Acceptance & Commitment – Control	−2.71	0.51	.001
	Integrative – Control	−1.56	0.52	.010
Total Score	Acceptance & Commitment – Integrative	−5.39	1.65	.005
	Acceptance & Commitment – Control	−17.93	1.60	.001
	Integrative – Control	−12.55	1.63	.001

The results of Table 4 showed that the difference between the effects of Acceptance and Commitment–based Couple Therapy and Integrative Couple Therapy on the components of belief in the destructiveness of conflict ($p = .030$), belief in the partner's unchangeability ($p = .019$), and the total score of dysfunctional beliefs ($p = .001$) was significant. Acceptance and Commitment–based Couple Therapy produced greater reductions in these components and in the total dysfunctional belief score compared to Integrative Couple Therapy.

Accordingly, the hypothesis test concluded that there is a significant difference between the effectiveness of Integrative Couple Therapy and Acceptance and Commitment–based Couple Therapy in reducing dysfunctional beliefs among infertile couples, and that Acceptance and Commitment–based Couple Therapy is the more effective approach for reducing dysfunctional beliefs in this population.

4. Discussion and Conclusion

The purpose of this study was to compare the effectiveness of Acceptance and Commitment–based Couple Therapy (ACT-CT) and Integrative Behavioral Couple Therapy (IBCT) in reducing dysfunctional beliefs among infertile couples. The results of the repeated-measures analyses revealed that both therapeutic approaches led to significant reductions in all components of dysfunctional beliefs—including beliefs about the destructiveness of conflict, mind-reading expectations,

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partner unchangeability, sexual perfectionism, and gender-related beliefs—at post-test and follow-up phases. However, ACT-CT demonstrated superior efficacy in reducing the belief in the destructiveness of conflict, the belief in partner unchangeability, and the total score of dysfunctional beliefs compared to IBCT. These findings suggest that although both therapeutic models are effective for infertile couples, ACT-CT may target the cognitive dimensions of relational distress more efficiently. This differential effect is particularly meaningful in the context of infertility, a condition known to amplify maladaptive cognitive patterns, emotional reactivity, and interpersonal sensitivity (Pasch & Sullivan, 2017; Pásztor et al., 2019).

The stronger outcomes of ACT-CT can be explained through its emphasis on psychological flexibility, cognitive defusion, acceptance of internal experiences, and values-guided behavior. These mechanisms directly address the cognitive fusion and experiential avoidance frequently observed among infertile couples. In infertility-related distress, couples often become entangled in rigid cognitive frames, such as "my partner will never change," "conflict destroys our relationship," or "my spouse should already know what I need." ACT-CT teaches individuals how to disengage from these unhelpful thoughts and reduce their literal influence, thereby facilitating healthier patterns of interaction. This aligns with earlier findings demonstrating the effectiveness of ACT in reducing irrational beliefs, maladaptive cognitions, emotional avoidance, and marital distress (Mousavi Haghighi et al., 2022; Rabiei et al., 2023). The present findings replicate and extend previous results indicating that ACT-CT enhances emotional acceptance, cognitive flexibility, and value-driven communication in distressed couples (Peterson et al., 2009), and improves empathy, attachment security, and emotional regulation in infertile couples (Ahmadi, 2025). As infertile couples experience chronic uncertainty, ACT's focus on acceptance and values-based coping may be particularly effective in mitigating catastrophic thinking and interpersonal rigidity.

In contrast, IBCT also produced improvements in dysfunctional beliefs, but to a lesser extent. This finding is consistent with the theoretical premise of IBCT, which prioritizes acceptance and behavioral change strategies rather than direct modification of cognitive content (Christensen & Jacobson, 1998). While IBCT helps couples reinterpret interpersonal conflicts through unified detachment and tolerance building, its mechanisms address cognitive distortions indirectly. The positive effects of IBCT observed in this study—shown by reductions across all belief components—are consistent with prior research documenting its effectiveness in improving marital satisfaction, communication patterns, emotional intimacy, and self-efficacy among infertile and distressed couples (Barraca et al., 2021; Vazirnia et al., 2021a, 2021b). Previous research has also highlighted that IBCT effectively disrupts maladaptive interaction cycles, reduces marital burnout, and promotes healthier emotional exchange (Sorush et al., 2021). Given that IBCT was originally developed to help couples navigate longstanding and emotionally charged relational patterns, its impact in the current study underscores its utility in infertility contexts, where chronic stress often leads to entrenched negative interactional cycles.

However, because IBCT does not primarily focus on altering maladaptive cognitions, it may yield smaller improvements in deeply rooted belief systems. This pattern mirrors prior comparative findings showing that IBCT is exceptionally effective for improving behavioral and emotional domains but somewhat less targeted in modifying cognitive distortions compared with ACT-oriented approaches (Keybollahi et al., 2022; Rajabi et al., 2013). Likewise, research on IBCT indicates that its change mechanisms rely heavily on empathic joining and emotional validation rather than cognitive restructuring (Snyder & Balderrama-durbin, 2022), which may explain why ACT-CT outperformed IBCT in reducing cognitive components such as belief in partner unchangeability. These cognitive beliefs tend to be rigid and reinforced by chronic infertility stressors; hence, interventions that challenge cognitive fusion directly may better disrupt deeply held beliefs.

The superiority of ACT-CT in this study is further supported by evidence that ACT is particularly effective in addressing dysfunctional beliefs among individuals experiencing chronic health-related distress. Prior studies have shown that ACT reduces worry, maladaptive coping, fusion with infertility-related thoughts, and psychological inflexibility—all factors that exacerbate dysfunctional relationship beliefs (Deyhimi et al., 2019; Sedghi et al., 2019). ACT's focus on mindfulness and present-focused awareness may also buffer against rumination and catastrophizing, which are prevalent in infertile couples due to the cyclical and unpredictable nature of fertility treatments. Through mindfulness, couples learn to observe relational conflicts without over-identifying with distressing thoughts, thereby reducing the belief that conflict is inherently destructive. The reduction observed in the belief in the destructiveness of conflict aligns with prior ACT

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findings showing decreased conflict reactivity and improved emotional attunement (Barraca et al., 2024). Moreover, ACT's emphasis on values helps couples reconnect with meaning and purpose beyond infertility itself, facilitating emotional resilience and reducing cognitive rigidity.

IBCT's significant but lesser impact on dysfunctional beliefs also aligns with its theoretical strengths. IBCT's acceptance interventions reduce mutual blame, soften emotional reactivity, and improve interactional stability—factors that may indirectly impact dysfunctional cognitions. The structured progression of IBCT, which includes case formulation, tolerance building, emotional acceptance, and behavioral exchanges, consistently enhances relationship satisfaction among distressed and infertile couples (Briggs et al., 2015; Lebow, 2015). In the context of infertility, where emotional volatility and communication breakdowns are common, IBCT's relational focus is crucial. However, its indirect impact on cognition likely accounts for the smaller reductions in core maladaptive beliefs compared with ACT-CT. This interpretation is consistent with research showing that IBCT yields strong results in relational functioning and distress reduction but is comparatively less rapid in altering cognitive schemas (Christensen & Jacobson, 1998; Taghavi Sureh Bargh & Mahdizadeh, 2022).

The present findings also fit within broader infertility literature emphasizing the psychological vulnerabilities of infertile couples. Studies demonstrate that infertility intensifies emotional distress, cognitive distortions, and relational fragility (Mokhtari Sorkhani et al., 2021; Yoshiko & Hiroya, 2022). Research confirms that psychological interventions targeting cognition, emotional regulation, and communication yield improvements in both relational and individual functioning (Çinar, 2025; Koser, 2020). This study's findings thus contribute to the growing evidence that mental-health and couple-based interventions are essential for addressing infertility-related distress. The observed changes in dysfunctional beliefs also align with systemic perspectives suggesting that emotional differentiation, fusion, and family-of-origin patterns shape couples' responses to infertility (Bowen, 2003). ACT-CT, by targeting internal processes such as emotional avoidance and rigid thought patterns, may facilitate deeper differentiation and autonomy, while IBCT, through acceptance and behavioral modification, helps reduce fusion and improve relational adaptation.

Another important dimension of the findings concerns the chronic emotional strain associated with infertility. Infertility is often perceived as a threat to personal identity, gender roles, and future life expectations (Obeagu et al., 2023). Maladaptive beliefs intensify under such stress, which may explain why cognitive-based interventions like ACT-CT demonstrated particularly strong outcomes. ACT helps infertile couples accept uncertainty and reframe distress, making it easier to challenge fixed expectations about marriage, gender, and partner behavior. These cognitive shifts can reduce both interpersonal conflict and emotional withdrawal. Additionally, ACT-based approaches have shown effectiveness in promoting emotional resilience, mindfulness, and adaptive decision-making, all of which are critical for couples undergoing repeated medical evaluations and treatments (Walser & O'Connell, 2023). Therefore, the present study's findings that ACT-CT outperformed IBCT in reducing key dysfunctional beliefs highlight the importance of targeted cognitive-change processes in infertility contexts.

In summary, both ACT-CT and IBCT significantly reduced dysfunctional relationship beliefs among infertile couples, but ACT-CT demonstrated superior outcomes for specific belief dimensions and overall dysfunctional cognition. These findings reaffirm the importance of integrating acceptance-based, mindfulness-driven, and value-focused strategies when treating relational distress associated with infertility. They also support the growing evidence that ACT is a particularly effective intervention for modifying maladaptive cognitive schemas in high-stress relational contexts. At the same time, the robust general improvements observed in both groups reinforce the value of couple therapy interventions more broadly for infertile populations.

The present study has several limitations. The sample size was relatively small, which may limit the generalizability of the findings. Participants were selected through purposive sampling from one infertility center, which restricts cultural and demographic diversity. The study also relied primarily on self-report instruments, which may be vulnerable to biases such as social desirability, response distortion, or emotional reactivity. Furthermore, therapy was delivered in structured formats, and treatment fidelity was not assessed through independent raters. The follow-up period was limited to three months, which may not capture long-term maintenance of cognitive or relational changes. Finally, the study did not examine potential moderating variables such as severity of infertility, treatment history, emotional regulation capacities, or gender differences, which may influence therapeutic outcomes.

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Future research should consider larger and more diverse samples of infertile couples to enhance the generalizability of findings. Longer follow-up periods would help determine the stability of cognitive and relational changes beyond the immediate treatment period. Comparative studies involving additional therapeutic models—such as Emotion-Focused Therapy, Cognitive-Behavioral Couple Therapy, or Systemic Family Therapy—may offer deeper insights into mechanisms of change. Research should also explore mediating variables such as psychological flexibility, unified detachment, emotional regulation, and attachment patterns to better understand how ACT-CT and IBCT exert their effects. Additionally, qualitative studies could enrich understanding of couples' subjective experiences during treatment and reveal nuanced relational processes that quantitative tools may not capture.

From a practical perspective, the findings highlight the importance of integrating ACT principles into infertility counseling and couple therapy programs. Mental health professionals can use ACT-CT to help couples reduce cognitive rigidity, increase acceptance, and foster value-driven relational behavior. IBCT remains a beneficial modality for improving emotional communication and relational patterns, suggesting that a combined or sequential treatment model may be particularly effective. Clinicians working with infertile couples should also provide psychoeducation to help clients understand how infertility intensifies cognitive distortions and emotional distress, and they should incorporate strategies that promote adaptability, empathy, and resilience in the face of chronic reproductive challenges.

Authors' Contributions

Authors contributed equally to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

Acknowledgments

We would like to express our gratitude to all individuals helped us to do the project.

Declaration of Interest

The authors report no conflict of interest.

Funding

According to the authors, this article has no financial support.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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