KMAN PUBLISHING INSTITUTE
Journal Website

Article history:
Received 30 June 2026
Revised 17 October 2026
Accepted 26 October 2026
Initial Publication 27 October 2026
Final Publication 01 January 2027

KMAN Counseling & Psychology Nexus

Volume 5, pp 1-15

E-ISSN: 3041-9026

Comparison of the Effectiveness of Existential Therapy and Schema Therapy on Marital Self-Regulation in Married Women with Multiple Sclerosis

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A r t i c l e I n f o

Article type:
Original Research

Section:
Health Psychology

How to cite this article:
Aqa Ali Akbari, L., Rahmanian, M., & Rafieipour, A. (2027). Comparison of the Effectiveness of Existential Therapy and Schema Therapy on Marital Self-Regulation in Married Women with Multiple Sclerosis. *KMAN Conseling and Psychology Nexus, 5*, 1-15.
http://doi.org/10.61838/kman.psynexus.6519

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A B S T R A C T

This study aimed to compare the effectiveness of existential therapy and schema therapy on marital self-regulation and its components in married women with multiple sclerosis. This quasi-experimental study employed a pretest-posttest control-group design with a three-month follow-up. The statistical population included married women with multiple sclerosis receiving services from the Iranian Multiple Sclerosis Society, Tehran Branch, during the first six months of 2026. Forty-five eligible participants were selected through purposive sampling and randomly assigned to existential therapy, schema therapy, and control groups, with 15 participants in each group. The two experimental groups received 10 weekly group sessions of existential therapy or schema therapy, while the control group received no psychological intervention during the study period. Marital self-regulation was assessed using the 16-item Marital Self-Regulation Questionnaire at pretest, posttest, and follow-up. Data were analyzed using repeated-measures analysis of variance and LSD post-hoc comparisons. Repeated-measures analysis showed significant time, group, and time-by-group interaction effects for marital self-regulation and its components in both intervention comparisons ($p < .05$). For existential therapy, the time-by-group interaction was significant for marital self-regulation ($F = 393.935$, $p < .001$, partial $\eta^2 = .934$), relational self-regulation ($F = 258.278$, $p < .001$, partial $\eta^2 = .902$), and relational effort ($F = 114.623$, $p < .001$, partial $\eta^2 = .804$). For schema therapy, significant interaction effects were also observed for marital self-regulation ($F = 171.169$, $p < .001$, partial $\eta^2 = .859$), relational self-regulation ($F = 101.862$, $p < .001$, partial $\eta^2 = .784$), and relational effort ($F = 136.165$, $p < .001$, partial $\eta^2 = .829$). LSD comparisons indicated that both interventions significantly outperformed the control group at posttest and follow-up, whereas differences between existential therapy and schema therapy were not statistically significant ($p > .05$). Both existential therapy and schema therapy were effective in improving marital self-regulation and its components in married women with multiple sclerosis, and neither intervention demonstrated statistically significant superiority over the other.

Keywords: *Existential Therapy, Schema Therapy, Marital Self-Regulation, Relational Self-Regulation, Multiple Sclerosis, Married Women*

1. Introduction

Multiple sclerosis (MS) is a chronic, inflammatory, demyelinating disease of the central nervous system that often develops during early and middle adulthood, thereby affecting individuals during years in which marital, family, occupational, and social roles are particularly salient. Beyond its neurological manifestations, MS can disrupt everyday functioning through fatigue, fluctuating physical abilities, cognitive difficulties, uncertainty regarding disease progression, dependence on others, and changes in self-concept. These challenges may become especially consequential for married women because the illness is experienced not only as an individual health condition but also within a relational system in which expectations, roles, emotional exchanges, and shared responsibilities must continually be renegotiated. Accordingly, the psychological consequences of MS can extend into marital functioning, influencing the ways in which women perceive interpersonal stressors, regulate their reactions toward their spouses, respond to conflict, communicate needs, and invest effort in preserving the relationship. Research has consistently shown that psychological and relational functioning in individuals with MS is associated with disease-related uncertainty, psychological distress, maladaptive beliefs, relationship quality, and fears concerning future deterioration (Khanlari Aziz et al., 2023). In this context, psychological interventions capable of strengthening adaptive relational processes may have particular clinical importance. Previous studies have demonstrated that interventions informed by existential, cognitive, acceptance-based, and schema-oriented approaches can improve psychological functioning in people with MS, including quality of life, meaning in life, emotional adjustment, fatigue, resilience, hope, and disease-related psychological symptoms (Dinparast et al., 2024; Farmani Shahreza et al., 2019; Hajibabaei et al., 2020; Hosseini Kiasari et al., 2014; Karbasdehi et al., 2021; Mansourzadeh et al., 2024; Namdari, 2013; Nazari et al., 2023; Parast et al., 2024). Nevertheless, the relational dimension of psychological adaptation deserves further attention because successful adjustment to chronic illness involves not merely reducing distress but also maintaining the capacity to respond intentionally and constructively within close relationships.

One relational construct that may be particularly relevant in this regard is marital self-regulation. Marital self-regulation refers to the capacity of individuals to monitor their own behavior within the marital relationship, evaluate the extent to which their actions correspond with desired relational goals, and deliberately modify ineffective patterns of responding. Rather than locating the cause of relational difficulties solely in the spouse, marital self-regulation emphasizes personal responsibility for one's contribution to interactional patterns and sustained effort toward improving the relationship. This construct includes both relational self-regulation, referring to deliberate monitoring and modification of one's own responses, and relational effort, referring to persistence and active investment in improving marital interactions. Such capacities may be especially important in chronic illness because unpredictable symptoms and functional limitations can increase interpersonal strain, intensify misunderstandings, and produce cycles of withdrawal, criticism, helplessness, or overdependence. When a woman is able to recognize her automatic responses, identify the assumptions underlying them, tolerate difficult emotions, and choose behaviors consistent with long-term relational values, marital interactions may become more flexible and adaptive. Conversely, psychological emptiness, maladaptive beliefs, unresolved relational schemas, and difficulty in taking responsibility for one's responses can undermine marital satisfaction and stability. Existential emptiness, for example, has been identified as a predictor of marital dissatisfaction, suggesting that difficulties in meaning, purpose, and engagement with life may be reflected in the quality of intimate relationships (Abbasi et al., 2022). Likewise, contemporary evidence suggests that early maladaptive schemas are associated with relationship satisfaction, perceived relational power, happiness, conflict, and romantic instability (Bozkaya, 2026; Hicks et al., 2026). These findings support the proposition that marital self-regulation may be influenced by both existential processes and schema-based cognitive-emotional patterns, making these two therapeutic approaches theoretically relevant for women coping with MS.

Existential therapy offers one potential pathway for strengthening marital self-regulation because it focuses on the individual's relationship with freedom, responsibility, meaning, choice, authenticity, isolation, and the limitations of human existence. Chronic illness can bring these existential concerns into sharper focus by challenging assumptions about predictability, control, identity, autonomy, and future possibilities. Women with MS may experience a discrepancy between their previous image of themselves and their present capacities, may struggle with uncertainty about future functioning, and may feel

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E-ISSN: 3041-9026

constrained by physical limitations or altered family roles. An existential approach does not primarily attempt to eliminate these realities; rather, it encourages individuals to recognize the possibilities for meaningful choice that remain within unavoidable limitations. Through heightened awareness of personal agency, individuals may become less inclined to respond automatically to marital stress and more capable of choosing how they wish to engage with their spouses. This emphasis on responsibility is directly relevant to marital self-regulation because adaptive relationship functioning requires attention to one's own behaviors rather than exclusive preoccupation with the partner's actions. Existential therapy may also facilitate more authentic communication by helping individuals clarify what they value in their relationships, recognize avoidance patterns, tolerate emotional discomfort, and act in ways that are consistent with chosen values. Evidence from marital populations supports these propositions. Existential group therapy has been associated with improvements in intimacy and marital satisfaction among married women (Mazarei Sotoudeh et al., 2022), while comparative research has shown that existential therapy can positively affect psychological well-being and marital disturbance among women experiencing relational conflict (Nameni et al., 2021). Existential therapy has also been found to improve marital forgiveness and family functioning among women affected by marital infidelity, indicating that its effects can extend beyond individual distress to central processes of relationship repair and family adjustment (Rezapour Mirsaleh et al., 2020). Furthermore, comparative evidence suggests that existential interventions can produce meaningful and sustained improvements in marital satisfaction and may operate through mechanisms related to personal responsibility, meaning reconstruction, and changes in interpersonal functioning (Abdekhodaie, 2021). More recent evidence has also shown the usefulness of existential psychotherapy for relational difficulties such as fear of intimacy and limited self-expression among women with marital conflicts (Dahmani et al., 2025).

The applicability of existential interventions to MS is also supported by studies conducted directly with this clinical population. Cognitive-existential group therapy has been reported to reduce psychological distress among patients with MS, suggesting that existentially oriented work may help individuals respond more adaptively to the emotional burden of chronic neurological illness (Hosseini Kiasari et al., 2014). In another study, cognitive-existential therapy was effective in reducing fatigue, demoralization, and perceived stress in patients with MS, indicating that the intervention may influence both emotional and illness-related dimensions of adaptation (Farmani Shahreza et al., 2019). Similarly, an existential-spiritual intervention improved quality of life and meaning in life among women with MS, highlighting the importance of meaning reconstruction and existential engagement in this population (Hajibabaei et al., 2020). Existential group therapy has also been associated with increased resilience and hope among married women with MS, two capacities that may support more constructive relational behavior under conditions of chronic stress (Namdari, 2013). Acceptance-oriented research with individuals with MS further indicates that addressing existential anxiety, emotional regulation, and acceptance of difficult internal experiences can produce significant psychological benefits (Karbasdehi et al., 2021). Taken together, these findings suggest that existential therapy may contribute to marital self-regulation indirectly by strengthening tolerance of uncertainty, responsibility for choice, emotional awareness, acceptance of limitations, and value-consistent behavior. For a married woman facing MS, these processes may translate into greater capacity to pause before reacting during conflict, differentiate controllable from uncontrollable aspects of relational stress, communicate needs more openly, and persist in adaptive marital efforts despite illness-related difficulties.

Schema therapy provides a different but potentially complementary pathway for improving marital self-regulation. Developed to address enduring cognitive, emotional, and behavioral patterns, schema therapy proposes that early maladaptive schemas originate when core emotional needs are repeatedly unmet and subsequently become organized as pervasive beliefs and emotional responses about the self, others, and relationships. These schemas may remain latent until activated by situations resembling earlier experiences of rejection, inadequacy, abandonment, dependence, vulnerability, or emotional deprivation. Chronic illness can constitute a potent schema-activating context because changes in physical ability, dependence, uncertainty, and altered roles may reactivate deeply held beliefs about weakness, defectiveness, abandonment, incompetence, or lack of support. Within marriage, schema activation can distort the interpretation of a spouse's behavior and contribute to automatic cycles of withdrawal, hostility, excessive reassurance seeking, submission, avoidance, or overcompensation. Schema therapy seeks to interrupt these patterns by helping individuals identify schemas and coping styles, distinguish

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E-ISSN: 3041-9026

current situations from schema-driven interpretations, modify maladaptive beliefs, process emotionally significant experiences, and strengthen the healthy adult mode. These goals closely correspond with marital self-regulation because effective self-regulation requires the ability to recognize one's own internal triggers, interrupt automatic responses, evaluate behavior against relationship goals, and replace maladaptive interaction patterns with more deliberate alternatives. Contemporary marital research supports the relevance of schema processes to intimate functioning. Early maladaptive schemas have been linked to marital happiness, relationship satisfaction, and perceptions of power within marriage (Bozkaya, 2026), while schema modes have been identified as cognitive-emotional predictors of relationship conflict and romantic instability (Hicks et al., 2026). In women experiencing serious relationship disruption, maladaptive schemas have also been associated with emotional divorce and vulnerability to marital infidelity (Shoaa Kazemi et al., 2026). These findings suggest that modification of schema-based responses may improve the individual's ability to regulate behavior constructively in the marital relationship.

Schema-oriented interventions have also demonstrated relevance in both marital and MS-related clinical contexts. Research comparing schema therapy with other psychological approaches has found beneficial effects on psychological distress, forgiveness, and interpersonal adjustment in women affected by severe marital difficulties, suggesting that changing entrenched schemas can alter how individuals interpret and respond to relational injuries (Hashemi Fesharaki & Salehi, 2026). Among people with MS, schema therapy has shown promising effects on a range of psychological and health-related outcomes. A randomized controlled trial demonstrated that schema therapy improved anxiety, depression, fatigue, quality of life, and sleep among patients with MS, indicating that addressing deep cognitive-emotional patterns can enhance adjustment to chronic neurological illness (Mansourzadeh et al., 2024). Comparative research has further shown that schema therapy can reduce chronic fatigue-related difficulties in patients with MS (Nazari et al., 2023), while studies comparing schema therapy with mindfulness-based techniques have documented its usefulness for sleep-related problems and existential concerns in this population (Dinparast et al., 2024; Parast et al., 2024). Moreover, the finding that mental health among individuals with MS can be predicted by relationship quality and early maladaptive schemas directly supports the relevance of schema processes to both personal and interpersonal functioning in MS (Khanlari Aziz et al., 2023). From a marital self-regulation perspective, schema therapy may be particularly useful because it encourages participants to identify the internal cognitive-emotional mechanisms underlying problematic marital behavior rather than simply reacting to the immediate behavior of the spouse. Recognition of schema activation can create a psychological interval between trigger and response, allowing the individual to replace automatic coping styles with more intentional behavior, communicate unmet emotional needs more directly, and assume greater responsibility for the interactional patterns to which she contributes.

Despite the growing literature on psychological interventions for MS and marital adjustment, several important gaps remain. First, many studies involving people with MS have focused primarily on individual outcomes such as distress, fatigue, quality of life, resilience, hope, sleep, or general psychological functioning rather than on self-regulatory processes within marriage (Farmani Shahreza et al., 2019; Hajibabaei et al., 2020; Hosseini Kiasari et al., 2014; Mansourzadeh et al., 2024; Namdari, 2013; Nazari et al., 2023). Second, studies addressing marital outcomes have commonly been conducted in populations defined by marital conflict, depression, infidelity, or general relationship dissatisfaction rather than among married women coping with a chronic neurological condition (Abdekhodaie, 2021; Dahmani et al., 2025; Hashemi Fesharaki & Salehi, 2026; Mazarei Sotoudeh et al., 2022; Nameni et al., 2021; Rezapour Mirsaleh et al., 2020). Third, although existential therapy and schema therapy are both theoretically relevant to marital self-regulation, they approach change through different mechanisms. Existential therapy emphasizes awareness, freedom, responsibility, authentic choice, and meaningful engagement, whereas schema therapy emphasizes identification and modification of deeply rooted cognitive-emotional patterns and maladaptive coping responses. A direct comparison of these approaches can therefore provide clinically useful information about whether one produces stronger effects on marital self-regulation or whether both constitute viable interventions despite their differing theoretical pathways. Recent findings linking existential processes to marital dissatisfaction and schema processes to relationship conflict further reinforce the rationale for examining these approaches in relation to marital functioning (Abbasi et al., 2022; Bozkaya, 2026; Hicks et al., 2026). Moreover, because MS can heighten dependence, uncertainty, and

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interpersonal vulnerability, interventions that enhance either responsible value-based choice or awareness and modification of maladaptive schemas may be especially useful for sustaining constructive marital behavior.

A further methodological consideration concerns the durability of therapeutic change. Improvements observed immediately after psychotherapy do not necessarily indicate that participants have incorporated new modes of self-regulation into their everyday marital relationships. Marital self-regulation is inherently behavioral and longitudinal: it involves repeated monitoring of one's own reactions, continuing effort to modify ineffective behaviors, and persistence in relationship-enhancing actions across changing circumstances. For women with MS, this issue may be even more important because disease symptoms and functional abilities can fluctuate, creating new relational stressors after treatment has ended. Consequently, follow-up evaluation is necessary to determine whether therapeutic gains persist beyond the immediate intervention period. Existing studies provide evidence that existential and schema-based treatments can generate meaningful change, but comparative evidence regarding their sustained effects on marital self-regulation among married women with MS remains limited. The convergence of findings on existential intervention, meaning-centered adaptation, schema processes, relationship quality, and psychological adjustment indicates a strong theoretical basis for such a comparison (Abdekhodaie, 2021; Mansourzadeh et al., 2024; Parast et al., 2024; Shoaa Kazemi et al., 2026). Examining both total marital self-regulation and its components can also clarify whether treatment-related change involves improved monitoring and modification of relational behavior, greater sustained relational effort, or both. Therefore, the aim of the present study was to compare the effectiveness of existential therapy and schema therapy on marital self-regulation and its components in married women with multiple sclerosis.

2. Methods and Materials

2.1. Study design and Participant

The present study employed a quasi-experimental design with three parallel groups and three assessment points, including pretest, posttest, and three-month follow-up. The statistical population consisted of all married women diagnosed with multiple sclerosis (MS) who were receiving support or services from the Iranian Multiple Sclerosis Society, Tehran Branch, during the first six months of the Iranian year 1405 (March–September 2026). The diagnosis of MS had previously been established by a medical specialist. Following coordination with the university and the Tehran Branch of the Iranian Multiple Sclerosis Society, potentially eligible women were screened according to the study inclusion and exclusion criteria. A total of 45 eligible participants were selected through purposive/convenience sampling and subsequently assigned randomly to three groups of 15 participants each: an existential therapy group, a schema therapy group, and a control group. The inclusion criteria were a confirmed diagnosis of multiple sclerosis, being married, being between 25 and 50 years of age, having at least lower-secondary education, absence of a severe physical condition that would prevent participation in the intervention sessions, sufficient physical and psychological capacity to participate in group sessions, and willingness to participate throughout the study. The exclusion criteria included withdrawal of consent, unwillingness to continue participation, major changes in marital status such as separation or divorce during the study period, initiation of a medication or medical treatment that substantially interfered with regular attendance at the intervention sessions, absence from more than two treatment sessions, and simultaneous participation in another structured psychological intervention. After receiving detailed information about the objectives, procedures, confidentiality of information, voluntary nature of participation, and right to withdraw from the research without adverse consequences, all participants provided written informed consent. Before the interventions, all three groups completed the marital self-regulation measure as the pretest (T1). The first experimental group then received existential therapy, while the second experimental group received schema therapy. The control group received no psychological intervention during the experimental period. To comply with ethical considerations, however, participants in the control group attended a two-hour educational session devoted exclusively to general information about multiple sclerosis, the course of the condition, general self-care, and responses to questions about the illness; no psychological strategies related to the study outcome were taught during this session. Following completion of the 10-session interventions, all three groups completed the posttest assessment (T2), and three months after the interventions, the same assessment was administered again as the follow-up evaluation (T3).

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2.2. Measures

Marital self-regulation was assessed using the Marital Self-Regulation Questionnaire developed by Wilson et al. (2005). The questionnaire consists of 16 items organized into two dimensions: relational self-regulation and relational effort. Items 1 through 10 assess relational self-regulation, whereas items 11 through 16 assess relational effort. Responses are recorded on a five-point Likert-type scale ranging from strong disagreement to strong agreement, yielding a possible total score between 16 and 80, with higher scores indicating a greater capacity for marital self-regulation. The instrument is intended to assess the extent to which individuals intentionally monitor, evaluate, and modify their behavior within an intimate relationship and the degree of sustained effort they devote to maintaining and improving relationship functioning. In the original validation study, Wilson et al. reported a two-factor construct corresponding to relational self-regulation and relational effort. Cronbach's alpha coefficients of .81 and .83 were reported for the two dimensions, respectively, and the correlation between the two subscales was .55. The Persian version has also demonstrated acceptable psychometric properties. Previous Iranian research reported Cronbach's alpha coefficients of .73 and .70 for the two dimensions, respectively, while confirmatory factor analysis supported the proposed two-factor structure. An overall Cronbach's alpha coefficient of .76 has also been reported for the Persian version. In the present study, the questionnaire was administered at pretest, immediately after completion of the interventions, and at the three-month follow-up, allowing changes in marital self-regulation over time and differences between the two therapeutic approaches and the control condition to be evaluated.

2.3. Interventions

Participants assigned to the existential therapy group attended 10 weekly group sessions conducted according to a structured protocol derived primarily from Yalom's existential therapeutic framework and adapted to the psychological and relational experiences of married women living with multiple sclerosis. The intervention emphasized exploration of lived experience, personal agency, responsibility, meaning, authenticity, interpersonal connectedness, adjustment to chronic illness, and more intentional engagement in marital relationships. The initial session focused on establishing psychological safety, group cohesion, confidentiality, voluntary participation, therapeutic expectations, and exploration of how living with MS had altered participants' perceptions of themselves, their relationships, and their everyday lives. Subsequent sessions addressed uncertainty associated with chronic illness and helped participants distinguish between circumstances outside their control and areas in which meaningful choices remained possible. Participants explored their relationship with their bodies and identities, including changes in self-perception and the effects of MS-related limitations on their sense of personal worth and relational functioning. Another session focused on interpersonal connectedness, experiences of emotional distance, the need to feel understood and supported, and strategies for cultivating more authentic communication with spouses and significant others. Later sessions emphasized freedom within limitation, personal choice, responsibility, and recognition of everyday opportunities for constructive action despite the restrictions associated with chronic illness. Participants were encouraged to identify personally important values, sources of meaning, realistic hope, and valued roles that could provide direction to their lives and relationships. Particular attention was given to marital self-regulation through examination of patterns of communication, individual responsibility during interpersonal disagreements, awareness of emotional reactions, recognition of personal needs, and deliberate selection of responses consistent with relationship values rather than automatic or avoidant reactions. Techniques included phenomenological exploration, empathic reflection, here-and-now processing, guided self-reflection, mindful awareness, value clarification, role-play, experiential dialogue, examination of personal choices, and between-session assignments. Participants practiced monitoring their emotional and behavioral responses in marital interactions, communicating needs more clearly, identifying alternative responses during conflict, and performing behaviors consistent with personally selected relational values. The final sessions focused on authenticity, self-acceptance, integration of therapeutic learning, identification of personally meaningful changes, development of an individualized self-care and relationship-maintenance plan, and preparation for maintaining therapeutic gains following termination of the group intervention.

The schema therapy group received a 10-session group intervention based on the schema therapy model developed by Young, Klosko, and Weishaar and adapted to married women with multiple sclerosis. The program was designed to increase awareness of maladaptive cognitive-emotional

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patterns and improve the participants' capacity to regulate their responses within marital relationships. The first session established group safety, confidentiality, therapeutic boundaries, and group cohesion and introduced the concepts of early maladaptive schemas, basic emotional needs, and the potential activation of longstanding schemas in response to chronic illness and marital stress. In subsequent sessions, participants identified their predominant maladaptive schemas, with particular attention to patterns such as defectiveness/shame, dependence/incompetence, abandonment, emotional deprivation, vulnerability, and other schemas that could affect perceptions of oneself or one's spouse. Participants explored the developmental origins of these schemas and examined situations in which illness-related limitations or interpersonal difficulties activated them. The intervention then introduced maladaptive coping styles, including surrender, avoidance, and overcompensation, and participants learned to recognize how these patterns influenced their responses to physical limitations, emotional distress, and marital conflict. Schema modes, particularly the vulnerable child, punitive or critical parent, maladaptive coping modes, and healthy adult mode, were introduced through guided imagery, role-play, chair work, and structured discussion. Middle sessions focused on reducing excessive self-criticism, developing self-compassion, strengthening healthy adult functioning, and promoting more balanced cognitive and emotional responses to the difficulties associated with MS. The marital component of the intervention focused directly on identifying schema-driven cycles of interaction between spouses, recognizing unmet emotional needs, differentiating current marital events from schema-based interpretations, and increasing individual responsibility for managing emotional and behavioral reactions. Participants examined real marital conflicts, identified triggering events and automatic interpretations, and practiced replacing habitual maladaptive responses with healthier communication and problem-solving behaviors. Cognitive restructuring, imagery rescripting, limited reparenting principles, empathic confrontation, behavioral pattern breaking, role-play, structured problem solving, and behavioral planning were used throughout the sessions. Participants were given between-session assignments involving monitoring schema activation, recording interpersonal triggers, practicing healthy communication, identifying alternative responses during disagreements, and intentionally selecting behaviors aligned with the healthy adult mode. The final sessions consolidated cognitive, emotional, and behavioral changes, strengthened participants' capacity for autonomous marital self-regulation, developed individualized plans for responding to future schema activation, and established strategies for maintaining healthier relationship patterns after termination of treatment.

2.4. Data Analysis

Data were analyzed using descriptive and inferential statistical procedures. Descriptive statistics, including the mean and standard deviation, were calculated for marital self-regulation scores separately for the existential therapy, schema therapy, and control groups at the pretest, posttest, and three-month follow-up assessments. Before conducting the primary inferential analysis, the relevant statistical assumptions were examined, including the distribution of scores, homogeneity of variances, and the assumptions associated with repeated measurements. The primary analysis was conducted using repeated-measures analysis of variance, with time representing the within-subject factor at three levels—pretest, posttest, and follow-up—and treatment condition representing the between-subject factor at three levels—existential therapy, schema therapy, and control. This analysis was used to determine whether marital self-regulation changed significantly over time, whether the three groups differed in their overall levels of marital self-regulation, and, most importantly, whether the pattern of change across the three measurement occasions differed according to treatment condition, as reflected in the group-by-time interaction. Where the assumption of sphericity was violated, an appropriate statistical correction, such as the Greenhouse–Geisser correction, was applied. When statistically significant overall or interaction effects were identified, adjusted pairwise comparisons were conducted to determine the specific differences between assessment occasions and treatment groups. Effect sizes were reported to indicate the magnitude of the observed intervention effects. Statistical tests were conducted using a two-tailed significance level of .05.

3. Findings and Results

The descriptive and inferential findings were examined to compare changes in marital self-regulation and its components across the existential therapy, schema therapy, and control groups at pretest, posttest, and three-month follow-up. Each group consisted of 15 married women with multiple sclerosis.

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E-ISSN: 3041-9026

Table 1

Means and Standard Deviations of Marital Self-Regulation and Its Components by Group and Measurement Occasion

Variable	Assessment	Control Group M	Control Group SD	Existential Therapy M	Existential Therapy SD	Schema Therapy M	Schema Therapy SD
Marital self-regulation	Pretest	45.93	6.724	46.67	5.972	48.87	8.123
	Posttest	44.40	5.902	58.07	6.088	61.07	6.227
	Follow-up	44.73	6.431	59.80	5.833	62.40	6.356
Relational self-regulation	Pretest	29.20	5.759	29.33	5.984	31.07	5.457
	Posttest	28.60	5.539	35.87	5.986	37.53	4.518
	Follow-up	28.80	5.722	36.87	5.780	38.20	4.491
Relational effort	Pretest	16.73	3.731	17.33	3.539	17.80	3.688
	Posttest	15.80	3.529	22.20	3.590	23.53	3.159
	Follow-up	15.93	3.474	22.93	4.183	24.20	3.212

As shown in Table 1, the three groups had relatively similar marital self-regulation scores at baseline, although the schema therapy group showed a somewhat higher pretest mean. In the control group, the mean marital self-regulation score decreased slightly from 45.93 at pretest to 44.40 at posttest and remained relatively unchanged at follow-up (M = 44.73). In contrast, the existential therapy group demonstrated a substantial increase from 46.67 at pretest to 58.07 at posttest, with a further slight increase to 59.80 at follow-up. The schema therapy group showed a comparable but numerically greater improvement, increasing from 48.87 at pretest to 61.07 at posttest and 62.40 at follow-up. Similar patterns were observed for both components. Relational self-regulation increased from 29.33 to 35.87 and 36.87 in the existential therapy group and from 31.07 to 37.53 and 38.20 in the schema therapy group across the three assessments, whereas the control group showed virtually no improvement. Likewise, relational effort increased from 17.33 at pretest to 22.20 at posttest and 22.93 at follow-up in the existential therapy group and from 17.80 to 23.53 and 24.20 in the schema therapy group. Overall, the descriptive findings indicated substantial and sustained improvement in marital self-regulation and both of its components following both psychological interventions, whereas scores in the control group remained largely stable or slightly declined.

Before testing the study hypotheses, the assumptions underlying repeated-measures analysis of variance were examined. Kolmogorov–Smirnov tests indicated no significant deviation from normality for marital self-regulation, relational self-regulation, or relational effort across the three groups and measurement occasions, with all obtained significance values exceeding .05. Box's M tests also supported the homogeneity of covariance matrices. For the comparison between existential therapy and the control group, Box's M values were 6.071 for marital self-regulation, 8.496 for relational self-regulation, and 9.625 for relational effort, with corresponding p values of .499, .277, and .204. For the comparison between schema therapy and the control group, Box's M values were 14.074, 13.948, and 9.606, with p values of .053, .056, and .205, respectively. Mauchly's test indicated that the sphericity assumption was satisfied for marital self-regulation and relational effort in the existential therapy comparison, whereas it was violated for relational self-regulation ($W = .691$, $\chi^2 = 9.990$, $p = .007$); consequently, Greenhouse–Geisser-corrected results were used for that component. In the schema therapy comparison, sphericity was violated for marital self-regulation ($W = .596$, $\chi^2 = 13.957$, $p = .001$) and relational self-regulation ($W = .503$, $\chi^2 = 18.545$, $p < .001$), and Greenhouse–Geisser corrections were therefore applied, whereas the assumption was satisfied for relational effort ($W = .916$, $\chi^2 = 2.363$, $p = .307$). Levene's tests were nonsignificant across pretest, posttest, and follow-up measurements for all study variables, indicating that the assumption of homogeneity of variances was also satisfied. Thus, the data were considered appropriate for repeated-measures analysis of variance.

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E-ISSN: 3041-9026

Table 2

Repeated-Measures Analysis of Variance for the Effects of Existential Therapy and Schema Therapy on Marital Self-Regulation and Its Components

Intervention	Variable	Effect	SS	df	MS	F	p	Partial η²
Existential therapy vs. control	Marital self-regulation	Time	610.067	2.000	305.033	256.570	<.001	.902
		Time × Group	936.689	2.000	468.344	393.935	<.001	.934
		Group	2170.711	1.000	2170.711	19.434	<.001	.410
	Relational self-regulation	Time	218.822	1.528	143.248	197.504	<.001	.876
		Time × Group	286.156	1.528	187.327	258.278	<.001	.902
		Group	598.044	1.000	598.044	5.997	.021	.176
	Relational effort	Time	98.156	2.000	49.078	60.037	<.001	.682
		Time × Group	187.400	2.000	93.700	114.623	<.001	.804
		Group	490.000	1.000	490.000	12.551	.001	.310
Schema therapy vs. control	Marital self-regulation	Time	671.667	1.425	471.395	113.081	<.001	.802
		Time × Group	1016.689	1.425	713.542	171.169	<.001	.859
		Group	3472.011	1.000	3472.011	27.266	<.001	.493
	Relational self-regulation	Time	201.267	1.336	150.633	76.708	<.001	.733
		Time × Group	267.267	1.336	200.029	101.862	<.001	.784
		Group	1020.100	1.000	1020.100	12.616	.001	.311
	Relational effort	Time	137.600	2.000	68.800	77.608	<.001	.735
		Time × Group	241.422	2.000	120.711	136.165	<.001	.829
		Group	728.178	1.000	728.178	21.169	<.001	.430

The repeated-measures analyses presented in Table 2 showed significant changes in marital self-regulation and both of its components over time in both intervention conditions. For existential therapy, the time effect for marital self-regulation was significant, $F = 256.570$, $p < .001$, partial $\eta^2 = .902$, and the time × group interaction was also significant, $F = 393.935$, $p < .001$, partial $\eta^2 = .934$. The significant between-group effect, $F = 19.434$, $p < .001$, partial $\eta^2 = .410$, further indicated that the overall pattern of marital self-regulation differed between the existential therapy and control groups. Significant time, interaction, and group effects were also obtained for relational self-regulation and relational effort. In particular, the time × group effects were large for relational self-regulation, $F = 258.278$, $p < .001$, partial $\eta^2 = .902$, and relational effort, $F = 114.623$, $p < .001$, partial $\eta^2 = .804$. A similar pattern emerged for schema therapy. The effect of time on marital self-regulation was significant, $F = 113.081$, $p < .001$, partial $\eta^2 = .802$, and the time × group interaction was significant, $F = 171.169$, $p < .001$, partial $\eta^2 = .859$. The between-group effect was also significant, $F = 27.266$, $p < .001$, partial $\eta^2 = .493$. Significant effects were likewise observed for relational self-regulation and relational effort, with substantial interaction effect sizes of .784 and .829, respectively. Collectively, these results demonstrate that both existential therapy and schema therapy produced significant improvements in marital self-regulation and its components relative to the control condition and that these improvements were maintained through the three-month follow-up.

Table 3

LSD Post-Hoc Comparisons of Marital Self-Regulation and Its Components

Outcome and Assessment	Comparison	Mean Difference	SE	p
Marital self-regulation, posttest	Control – Existential therapy	-13.67	2.218	<.001
	Control – Schema therapy	-16.67	2.218	<.001
	Existential therapy – Schema therapy	-3.00	2.218	.183
Marital self-regulation, follow-up	Control – Existential therapy	-15.07	2.268	<.001
	Control – Schema therapy	-17.67	2.268	<.001
	Existential therapy – Schema therapy	-2.60	2.268	.258
Relational self-regulation, posttest	Control – Existential therapy	-7.27	1.966	.001
	Control – Schema therapy	-8.93	1.966	<.001

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	Existential therapy – Schema therapy	-1.67	1.966	.401
Relational self-regulation, follow-up	Control – Existential therapy	-8.07	1.959	<.001
	Control – Schema therapy	-9.40	1.959	<.001
	Existential therapy – Schema therapy	-1.33	1.959	.500
Relational effort, posttest	Control – Existential therapy	-6.40	1.253	<.001
	Control – Schema therapy	-7.73	1.253	<.001
	Existential therapy – Schema therapy	-1.33	1.253	.293
Relational effort, follow-up	Control – Existential therapy	-7.00	1.331	<.001
	Control – Schema therapy	-8.27	1.331	<.001
	Existential therapy – Schema therapy	-1.27	1.331	.347

As shown in Table 3, LSD post-hoc comparisons indicated that both intervention groups had significantly higher marital self-regulation scores than the control group at both posttest and follow-up. At posttest, the difference between the control and existential therapy groups was -13.67 ($p < .001$), while the difference between the control and schema therapy groups was -16.67 ($p < .001$). At follow-up, these differences increased to -15.07 and -17.67, respectively, and remained statistically significant (both $p < .001$). However, the direct differences between existential therapy and schema therapy were not statistically significant either at posttest (mean difference = -3.00, $p = .183$) or follow-up (mean difference = -2.60, $p = .258$). The same pattern was found for relational self-regulation: both existential therapy and schema therapy significantly outperformed the control group at posttest and follow-up, whereas the differences between the two active treatments were nonsignificant at both measurement occasions. For relational effort, existential therapy and schema therapy also resulted in significantly higher scores than the control condition at posttest and follow-up, while the direct comparison between the two interventions was nonsignificant at posttest (mean difference = -1.33, $p = .293$) and follow-up (mean difference = -1.27, $p = .347$). Therefore, although schema therapy produced numerically higher means than existential therapy across marital self-regulation and both components, the differences between the two therapeutic approaches did not reach statistical significance. The findings consequently indicate that both interventions were effective in improving marital self-regulation among married women with multiple sclerosis, with no evidence that either treatment was statistically superior to the other.

4. Discussion

The present study compared the effectiveness of existential therapy and schema therapy in improving marital self-regulation among married women with multiple sclerosis. The findings showed that both existential therapy and schema therapy produced significant improvements in overall marital self-regulation, relational self-regulation, and relational effort compared with the control group. These improvements were evident at posttest and were maintained at the three-month follow-up. The significant time-by-group interactions further indicated that the observed changes could not be attributed merely to the passage of time, because participants in the intervention groups demonstrated substantially different trajectories from those in the control condition. Although the schema therapy group obtained numerically higher mean scores than the existential therapy group at both posttest and follow-up, the direct differences between the two active interventions were not statistically significant. Therefore, the principal finding of the study is that both therapeutic approaches were effective in strengthening marital self-regulation and its components, while neither demonstrated a statistically superior effect over the other. This pattern suggests that existential therapy and schema therapy, despite their theoretical and technical differences, may influence overlapping psychological processes that enable married women with multiple sclerosis to monitor their relational behavior more effectively, modify dysfunctional interaction patterns, and sustain greater effort toward maintaining constructive marital relationships.

The beneficial effect of existential therapy on marital self-regulation is consistent with previous findings indicating that existentially oriented interventions can improve dimensions of marital and interpersonal functioning. Existential group therapy has been shown to increase intimacy and marital satisfaction among married women, suggesting that attention to meaning, responsibility, authenticity, and interpersonal presence can promote healthier marital interactions (Mazarei Sotoudeh et al., 2022). Similarly, existential therapy has been associated with improvements in psychological well-being and reductions in marital disturbance among women experiencing relationship conflict (Nameni et al., 2021). Its effectiveness in enhancing marital forgiveness and family

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functioning has also been demonstrated among women affected by marital infidelity (Rezapour Mirsaleh et al., 2020). Comparative evidence further indicates that existential therapy can produce meaningful and relatively stable improvements in marital satisfaction and relational functioning (Abdekhodaie, 2021). More recent findings showing that existential psychotherapy can improve relational difficulties such as fear of intimacy and self-expression among women with marital conflicts also support the current findings (Dahmani et al., 2025). Taken together, these studies indicate that existential interventions are capable of influencing relational processes rather than merely reducing individual psychological symptoms, which provides an appropriate empirical context for understanding the improvement in marital self-regulation observed in the present study.

The effect of existential therapy may be explained first by its emphasis on personal responsibility and conscious choice. Marital self-regulation requires individuals to direct attention toward their own behavior, assess whether their responses facilitate or undermine their relational goals, and deliberately modify ineffective patterns. This orientation is highly compatible with the existential view that, even when individuals cannot control all circumstances of their lives, they retain some degree of freedom in deciding how to respond to those circumstances. Multiple sclerosis can generate circumstances that are difficult or impossible to control, including fluctuations in physical functioning, fatigue, changes in everyday roles, and uncertainty concerning future capabilities. Under such conditions, a person may gradually develop a passive or reactive interpersonal stance in which conflict and dissatisfaction are attributed primarily to the illness, the spouse, or external limitations. Existential therapy can challenge such passivity by helping participants differentiate uncontrollable circumstances from areas in which choice remains possible. By recognizing that they can still choose how to communicate, how to express dissatisfaction, how to interpret relational events, and how to respond during conflict, participants may develop greater behavioral self-regulation within marriage. This explanation is compatible with findings showing that existentially based treatment can improve psychological adaptation and relational functioning through increased responsibility, meaning, and active engagement with life (Abbasi et al., 2022; Abdekhodaie, 2021).

A second explanation concerns the role of meaning and existential coherence. Chronic illness may disrupt previously held assumptions about identity, future plans, independence, family roles, and personal value. When such disruptions are not integrated into a meaningful framework, marital interactions can become increasingly reactive because frustration, helplessness, and disappointment may be expressed indirectly within the relationship. Previous research has shown that existential emptiness can contribute to marital dissatisfaction, indicating that difficulties in meaning and purpose may influence intimate relationships (Abbasi et al., 2022). In the present study, existential therapy encouraged participants to clarify values, reconsider meaningful roles, and identify ways of living purposefully despite illness-related limitations. This process may have reduced the tendency to respond to marital stress solely from the perspective of loss or restriction and instead promoted more deliberate relational behavior. Studies among women with multiple sclerosis have shown that existential and existential-spiritual interventions can improve meaning in life, quality of life, resilience, and hope (Hajibabaei et al., 2020; Namdari, 2013). Such changes may create a psychological foundation for better marital self-regulation because individuals who possess a clearer sense of meaning and direction may be more willing to tolerate short-term relational discomfort in pursuit of longer-term marital goals.

The present findings are also consistent with research demonstrating the usefulness of existentially informed interventions specifically in people with multiple sclerosis. Cognitive-existential group therapy has been associated with reduced psychological distress in patients with MS (Hosseini Kiasari et al., 2014), while cognitive-existential therapy has also been shown to improve fatigue, demoralization, and perceived stress (Farmani Shahreza et al., 2019). In addition, existentially oriented interventions have improved quality of life and meaning in life among women with MS (Hajibabaei et al., 2020), and acceptance-based interventions have been found to strengthen cognitive-emotional regulation and adaptation in this population (Karbasdehi et al., 2021). Although these studies did not directly assess marital self-regulation, their findings support the idea that interventions addressing meaning, acceptance, responsibility, and emotional awareness can improve the psychological resources required for adaptive interpersonal behavior. In the present study, these resources may have allowed participants to better regulate their reactions during marital interactions, become more aware of the impact of their behavior on the relationship, and increase sustained effort toward maintaining constructive patterns of communication.

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Schema therapy also significantly improved marital self-regulation, relational self-regulation, and relational effort. This finding is consistent with evidence indicating that early maladaptive schemas and schema modes are closely related to marital functioning. Research has shown that early maladaptive schemas influence marital dynamics through their associations with relationship satisfaction, happiness, and perceived power within marriage (Bozkaya, 2026). Similarly, maladaptive schema modes have been identified as important cognitive-emotional predictors of relationship conflict and romantic instability (Hicks et al., 2026). In women experiencing serious marital difficulties, incompatible schemas have also been associated with emotional disengagement and relational instability (Shoaa Kazemi et al., 2026). These findings suggest that marital behavior cannot always be understood exclusively in terms of the immediate interpersonal situation, because current interactions may activate long-standing beliefs concerning abandonment, inadequacy, mistrust, emotional deprivation, dependence, or vulnerability. When these schemas are activated, individuals may interpret their partner's behavior through rigid cognitive-emotional filters and respond in ways that reinforce conflict. The significant improvement observed after schema therapy therefore appears theoretically coherent, because the intervention directly targeted the underlying structures that may interfere with adaptive marital self-regulation.

Schema therapy may have improved marital self-regulation by increasing participants' awareness of the distinction between external events and schema-driven interpretations. A relatively neutral action by a spouse can trigger disproportionately intense emotional reactions when interpreted through an activated maladaptive schema. For example, limited availability from a partner may be interpreted as abandonment, disagreement may be interpreted as rejection, and receiving help may be interpreted as evidence of personal incompetence. These interpretations can then generate coping responses such as withdrawal, submission, excessive reassurance seeking, anger, or overcompensation. By helping participants identify these patterns, schema therapy may have created a greater capacity to interrupt automatic sequences between trigger, interpretation, emotion, and behavior. This is particularly important for marital self-regulation, which depends on self-observation and behavioral adjustment rather than reflexive responding. The present results are consistent with evidence linking early maladaptive schemas to the mental health and relationship quality of people with multiple sclerosis (Khanlari Aziz et al., 2023). Because MS can increase feelings of dependence, uncertainty, and vulnerability, schema activation may be particularly likely in this population, making schema-focused intervention clinically relevant.

The effectiveness of schema therapy in the present study is also supported by research conducted with patients with multiple sclerosis. A randomized controlled trial demonstrated that schema therapy can improve a range of psychological and functional outcomes in patients with MS, including anxiety, depression, fatigue, quality of life, and sleep (Mansourzadeh et al., 2024). Other research has shown beneficial effects of schema therapy on chronic fatigue-related problems in patients with MS (Nazari et al., 2023), and comparisons between schema therapy and mindfulness-based approaches have indicated improvements in psychological and sleep-related functioning (Dinparast et al., 2024; Parast et al., 2024). These studies suggest that schema therapy can produce meaningful changes in people with MS by modifying persistent cognitive-emotional patterns that are activated by illness-related challenges. The present study extends this line of evidence by indicating that these effects may also be reflected in marital functioning, particularly in the ability to monitor one's own responses and maintain constructive effort within the marital relationship.

Another important finding was that both interventions improved relational self-regulation. This component reflects the individual's ability to observe and evaluate personal behavior within the relationship and to make intentional changes when current behavior does not contribute to desired relational outcomes. Existential therapy may strengthen this capacity through increased self-awareness, personal accountability, and authentic decision-making, whereas schema therapy may strengthen it through recognition of schemas, coping modes, and recurring maladaptive interpersonal patterns. Although these mechanisms differ in terminology and theoretical origin, both approaches encourage individuals to move from automatic responding toward reflective and intentional action. This common element may partly explain why both therapies were effective and why no significant difference emerged between them. Existential therapy encourages the individual to ask what kind of partner she chooses to be under difficult circumstances, whereas schema therapy encourages her to identify which schema or mode is shaping the current reaction and whether a healthier response is available. In practice, both processes can result in increased

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awareness of one's contribution to marital interactions and greater capacity to modify problematic behavior.

Both interventions also significantly improved relational effort. Relational effort refers to persistence in attempting to improve the relationship and the willingness to invest cognitive, emotional, and behavioral resources in constructive marital functioning. Chronic illness may gradually weaken such effort when repeated stressors create exhaustion, hopelessness, or beliefs that relationship difficulties cannot be changed. Existential therapy may counteract this process by reconnecting participants with personally meaningful values and helping them understand sustained relational effort as an intentional choice rather than merely an obligation. Schema therapy may increase relational effort by reducing the influence of maladaptive coping styles such as avoidance, surrender, or overcompensation and replacing them with healthier adult responses. Previous research on existential interventions has shown improvements in marital satisfaction, intimacy, family functioning, and relational adjustment (Dahmani et al., 2025; Mazarei Sotoudeh et al., 2022; Rezapour Mirsaleh et al., 2020), while schema-oriented studies demonstrate that modifying maladaptive schemas can improve psychological adjustment and interpersonal functioning (Bozkaya, 2026; Hashemi Fesharaki & Salehi, 2026). These findings support the interpretation that both therapeutic models can increase the willingness and psychological capacity required for sustained investment in marital relationships.

The absence of a statistically significant difference between existential therapy and schema therapy is itself theoretically informative. Although schema therapy produced somewhat higher descriptive means, the magnitude of these differences was insufficient to establish superiority. This finding may indicate that marital self-regulation is a multidetermined construct that can be improved through more than one therapeutic pathway. Existential therapy works primarily through meaning, freedom, responsibility, authenticity, and value-consistent action, whereas schema therapy works through modification of maladaptive schemas, coping styles, and emotional modes. Nevertheless, both approaches increase self-awareness, challenge automatic interpersonal behavior, encourage responsibility for one's responses, and promote more deliberate action. These shared therapeutic processes may be especially relevant to marital self-regulation and may explain why both interventions produced comparable outcomes. Comparable findings in other domains have shown that different evidence-based psychological interventions can yield similar overall outcomes despite operating through partially distinct mechanisms (Abdekhodaie, 2021; Hashemi Fesharaki & Salehi, 2026). The present results therefore suggest that the choice between existential therapy and schema therapy may reasonably depend on clinical formulation, participant preference, therapist expertise, and the dominant psychological difficulties of the patient rather than on an assumption that one approach is universally more effective.

5. Conclusion

The maintenance of treatment gains at the three-month follow-up further strengthens the clinical significance of the findings. Marital self-regulation is not a transient emotional state but a continuing process of observing, evaluating, and adjusting one's behavior over time. The persistence of higher scores after completion of therapy suggests that participants may have internalized skills or perspectives that continued to influence their marital interactions outside the treatment setting. In existential therapy, this durability may reflect continued application of value clarification, responsibility, awareness of choice, and authentic communication. In schema therapy, it may reflect continued recognition of schema activation, use of healthier coping responses, and strengthening of healthy adult functioning. The slight additional improvement observed descriptively at follow-up in both treatment groups may suggest that some therapeutic effects consolidated through continued use in everyday marital situations. This interpretation is consistent with previous studies demonstrating meaningful and sustained psychological effects of existential and schema-based interventions across clinical and marital populations (Abdekhodaie, 2021; Mansourzadeh et al., 2024). Overall, the results support the use of both approaches as potentially valuable interventions for strengthening adaptive marital functioning among women living with multiple sclerosis.

Several limitations should be considered when interpreting the findings. The sample consisted of only 45 married women with multiple sclerosis who were recruited from a single MS-related service setting in Tehran, which limits the generalizability of the findings to women from other geographical regions, cultural contexts, socioeconomic groups, or healthcare settings. The relatively small sample size may also have reduced statistical power for detecting more subtle differences between existential therapy and schema therapy, particularly because the descriptive means suggested somewhat greater improvement in the schema

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E-ISSN: 3041-9026

therapy group despite the absence of statistically significant between-treatment differences. In addition, marital self-regulation was assessed using a self-report questionnaire, making the findings potentially vulnerable to response bias, social desirability, and participants' subjective perceptions of change. The study did not include reports from spouses or direct behavioral observations of marital interactions. The follow-up period was limited to three months, and therefore the long-term stability of treatment effects remains uncertain. Furthermore, because the interventions were delivered in group format, nonspecific therapeutic factors such as group cohesion, perceived support, and interaction with other participants may have contributed to the observed improvements.

Future studies should replicate the present research using larger and more diverse samples recruited from multiple medical centers and MS associations in different regions. Increasing sample size would allow more precise estimation of treatment effects and provide greater statistical power for determining whether small differences between existential therapy and schema therapy are clinically meaningful. Longer follow-up periods, such as six months or one year, are recommended to determine whether gains in marital self-regulation remain stable over time. Future research could also include spouse-reported measures, observational assessments of couple interaction, and clinician-rated indicators to complement self-report data. Dyadic designs involving both partners would be particularly valuable because marital self-regulation occurs within an interpersonal system in which changes in one spouse may influence the behavior of the other. Researchers may also investigate potential mediators of treatment effects, such as personal responsibility, meaning in life, schema activation, emotional regulation, self-compassion, or communication quality, in order to clarify how the two therapies produce change. Comparative studies could additionally examine whether particular participant characteristics predict a better response to one intervention than the other.

The findings suggest that both existential therapy and schema therapy can be incorporated into psychological services for married women with multiple sclerosis when difficulties in marital self-regulation are present. Clinicians may select the intervention according to the individual's dominant psychological and relational patterns. Existential therapy may be especially appropriate when difficulties center on loss of meaning, reduced agency, uncertainty, identity disruption, passivity, or difficulty accepting responsibility within the relationship, whereas schema therapy may be particularly useful when recurrent relational conflicts appear to be driven by rigid beliefs, longstanding interpersonal patterns, emotional triggers, or maladaptive coping styles. MS treatment centers and patient-support organizations may benefit from integrating structured group psychological interventions alongside routine medical care. Therapists should also emphasize the transfer of therapeutic learning into everyday marital situations through regular behavioral practice, self-monitoring, communication exercises, and maintenance planning, because the clinical value of treatment ultimately depends on whether new ways of responding become part of participants' continuing marital interactions.

Authors' Contributions

Authors equally contributed 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. The study was approved by the Research Council and the Research Ethics Committee of Islamic Azad University, North Tehran Branch, under ethics code IR.IAU.TNB.REC.1405.048. Participants were assured that all information would remain

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confidential and would be reported only in aggregate form for research purposes. After completion of data collection, appropriate educational material was also made available to participants in the control group.

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E-ISSN: 3041-9026