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Original Article

The Effectiveness of Resilient Dialectical Behavior Therapy and Dialectical Behavior Therapy on Coping Strategies and Resilience in Women Experiencing Marital Burnout

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Abstract

Background: Marital burnout significantly affects many women, leading to emotional distress and decreased quality of life. The present study aimed to investigate the effectiveness of resilient dialectical behavior therapy (RDBT) and dialectical behavior therapy (DBT) on improving coping strategies and resilience in women experiencing marital burnout.

Methods: This quasi-experimental study employed a pre-test, post-test, and two-month follow-up design to evaluate the efficacy of Dialectical Behavior Therapy (DBT) and Relational Dialectical Behavior Therapy (RDBT) in addressing marital burnout among women aged 25-50. The study participants were recruited from counseling centers in Isfahan, Iran, during the Spring of 2023. A convenience sample of 45 women was randomly allocated to three groups: DBT (n=15), RDBT (n=15), and a control group (n=15). The experimental groups received nine weekly, 60-minute therapy sessions, while the control group received no intervention. The Coping Inventory for Stressful Situations (CISS) and Connor-Davidson Resilience Scale (CD-RISC) were administered at pre-test, post-test, and follow-up. Repeated measures ANOVA and Bonferroni post-hoc tests were used to analyze the data, which was processed using SPSS version 27.

Results: Both interventions had a significant positive effect on improving coping strategies and resilience in women experiencing marital burnout (P<0.001). At post-test, the RDBT group demonstrated significantly higher levels of problem-focused coping than the DBT group, with mean scores of 16.80 (95% CI: 14.43, 19.17) and 7.20 (95% CI: 4.83, 9.57), respectively. Both groups exhibited decreases in emotion-focused coping, with the RDBT group showing a more pronounced decline (-10.47, 95% CI: -12.83, -8.11) compared with the DBT group (-6.54, 95% CI: -8.91, -4.17). Similarly, the RDBT group demonstrated a greater reduction in avoidant coping (-11.13, 95% CI: -13.59, -8.67) compared with the DBT group (-7.93, 95% CI: -10.3, -5.56). Finally, both groups exhibited significant increases in resilience, with the RDBT group showing slightly higher levels at post-test (33.13, 95% CI: 30.77, 35.49) compared with the DBT group (31.14, 95% CI: 28.77, 33.51).

Conclusions: The findings of this study demonstrate the efficacy of both DBT and RDBT in enhancing coping strategies and resilience among women experiencing marital burnout. These results underscore the potential of DBT and RDBT in addressing the psychological challenges associated with marital distress.

Keywords: Coping skills, Dialectical behavior therapy, Family conflict, Resilience, Women

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1. Introduction

The family, as a social, emotional, and personality-shaping unit, is formed through the marital bond between a man and a woman (1). The quality of relationships within the family plays a significant role in shaping attitudes, social feedback, and the development of social skills among family members, and the foundation of relationships within the family is based on the relationship between husband and wife (2). A cornerstone of familial resilience, durability, and growth is the establishment of harmonious relationships characterized by compatibility and mutual understanding among family members, particularly between spouses (3). The emergence of marital discord and conflict can precipitate marital burnout within couples (4).

Marital burnout, a gradual decline in emotional connection with one's spouse, is characterized by feelings of alienation, apathy, and indifference between partners. Positive emotions are replaced by negative ones, leading to a state of physical, emotional, and mental exhaustion arising from prolonged exposure to emotional demands (5, 6). As noted by Alsawalqa (7), marital burnout is a decline in love and affection that arises from prolonged exposure to stress, pain, and physical, psychological, and emotional pressures. This

condition can result from separation from work and other meaningful relationships, leading to significant consequences for marital relationships and imposing substantial psychological and social costs on individuals and society.

One of the factors influencing marital burnout is coping strategies (8). Coping strategies are employed as methods of dealing with issues in stressful situations, with each strategy having both constructive and destructive aspects (9). If coping strategies are not used and managed correctly in a situation, they can negatively impact quality of life and mental health. Individuals who employ ineffective coping strategies often experience low levels of psychological well-being and physical health, including stress and anxiety, along with decreased self-esteem and social adjustment. These individuals are more likely to experience marital burnout (10). Research indicated that teaching problem-focused coping strategies is effective in reducing marital conflict and divorce rates (11). Elshaer (12) found that women with poor coping strategies experienced greater distress and harm. Furthermore, Rodrigues and co-workers (13) demonstrated that appropriate and adaptive coping strategies can lead to effective management of psychological stress. Another factor that can be significantly related to marital burnout is individual resilience (14).

Resilience is the adaptation of one's level of control to environmental conditions (15). In the context of human behavior, resilience is often considered a trait related to personality and character, and refers to the ability to cope with and recover from stressful and challenging situations (16). Resilience essentially facilitates successful adaptation in life. Resilience is a multidimensional trait that varies from individual to individual and can develop or decline over time (17). Through the process of learning, organization, and adaptation, resilience helps individuals defend their health, happiness, and meaningful life against internal and external stressors (18). Studies have consistently linked low resilience in marital relationships to a host of negative outcomes, including marital dissatisfaction, depression, anxiety, diminished quality of life, and heightened marital conflict (16, 19). In line with these findings, Clement-Carbonell and colleagues (20) observed a positive association between individual resilience and family cohesion, effective communication, and functional family dynamics. Conversely, individuals with lower resilience reported more difficulties in their family relationships.

Various therapeutic and educational methods have been employed to address the problems of couples, as well as women and families. Dialectical behavior therapy (DBT) is one such therapeutic approach used to improve the psychological, emotional, and interpersonal components of these individuals. DBT introduces four intervention components: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness as components of acceptance and change (21). This therapy is grounded in behaviorism, dialectical philosophy, and mindfulness meditation (22). Standard DBT is characterized by five key functions: enhancing behavioral skills, fostering motivation for skillful behaviors, facilitating generalization of treatment gains to real-world settings, establishing a therapeutic environment that reinforces effective behaviors, and cultivating therapist competence and motivation (23). Empirical evidence supports DBT's efficacy in mitigating marital conflict (24) and augmenting marital satisfaction (25).

In addition to DBT, resilience is a newer intervention that holds a special place in various fields of psychology, including family development and mental health. Resilience refers to the fundamental characteristics or qualities that enable individuals to cope with adversity, serving as a positive adaptation to stress and an inherent self-correcting mechanism of human beings. It is considered a relatively stable individual personality trait (26). Resilience is an active process of persevering, self-affirmation, and thriving in response to crisis and challenge. It does not imply the absence of risk factors in life but rather the presence of psychosocial and supportive factors that lead to positive outcomes in people's lives. Supportive factors include positive thinking, self-confidence, control of negative emotions, problem-solving skills, finding meaning, adaptability, self-belief, high tolerance for inadequacy, self-acceptance, a sense of humor, support from others, and curiosity (27). Having resilience in a family creates a protective environment where family members actively engage in physical, emotional, and mental well-being, minimizing threats to family growth and health (28). Resilience is positively correlated with quality of life. It serves as a coping resource for stress at the societal level

during collective crises and as protective factors that help individuals (29).

Given the high prevalence of marital burnout among women and its significant role as a leading cause of divorce, the use of novel therapeutic approaches holds great promise. Accordingly, this study aimed to compare the effectiveness of DBT and RDBT on coping strategies and resilience in women experiencing marital burnout.

2. Methods

2.1. Design and Participants

The study employed a quasi-experimental design with a pre-test, post-test, and two-month follow-up evaluation. A control group was included for comparison. The study population comprised all women aged 25-50 years experiencing marital burnout who had attended counseling centers in Isfahan in the Spring of 2023. A sample size of 45 women was calculated using G*Power software, with a significance level of 0.05, and a test power of 0.90. The DBT, RDBT, and control groups displayed mean resilience scores of 63.80 (SD=9.80), 68.00 (SD=4.40), and 31.70 (SD=8.21), respectively. To minimize selection bias and ensure equal distribution of potential confounding variables across the experimental groups, a simple random sampling method was employed. Each participant was assigned a unique identification number, and random numbers were generated from a table. Individuals corresponding to these random numbers were then sequentially allocated to the two experimental groups (DBT and RDBT) and the control group (Figure 1). To minimize bias, participants were blinded to their group assignment. Additionally, the researchers administering the assessments and analyzing the data were also kept blind to group allocation. Inclusion criteria included informed consent, age range, low scores on the marital burnout questionnaire, a marital history of over three years, and no concurrent participation in other psychological programs. The exclusion criteria were participant withdrawal and excessive absences from the intervention program.

2.2. Procedure

After obtaining ethical approval, a call for participants was announced to counseling centers

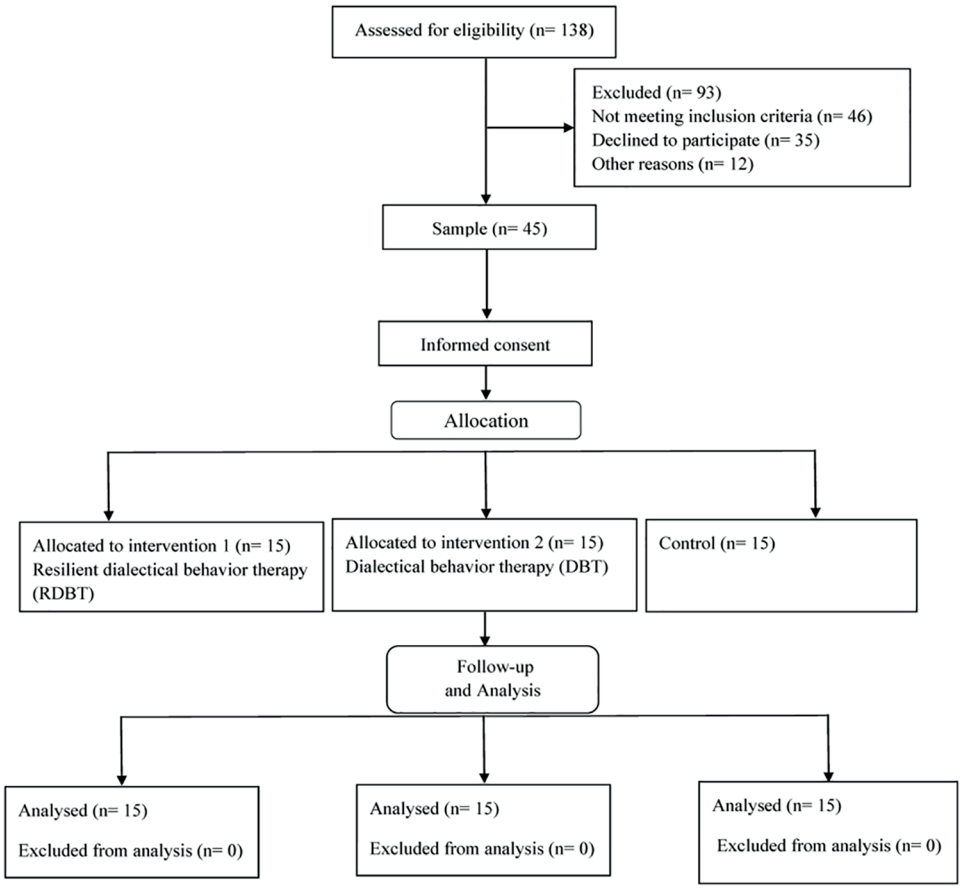

Figure 1: The figure shows the flow diagram of the sampling process.

in Isfahan, Iran. We selected 45 women with marital burnout, identified by scoring below the mean on a marital burnout questionnaire. Informed consent was obtained following a detailed explanation of the study objectives. The experimental groups received nine 60-minute DBT and RDBT therapy sessions, conducted once a week. The intervention program was implemented by the first author at the counseling center of the municipal cultural center in Isfahan, Iran. The control group received no intervention during this period and was placed on a waiting list. A summary of the therapy sessions is provided in Tables 1 and 2. All groups completed research questionnaires at the pre-test, post-test, and two-month follow-up stages.

The primary objective of this study was to evaluate the efficacy of DBT and RDBT interventions in enhancing coping strategies and resilience among women experiencing marital burnout. To delve deeper into the specific effects of these interventions, the study also explored secondary outcomes, including comparisons of problem-focused coping, emotion-focused coping, avoidant coping, and resilience. By examining these secondary aspects, the study aimed to identify any potential differences in the effect of DBT and RDBT on various dimensions of coping and resilience.

2.3. Research Instrument

2.3.1. Coping Inventory for Stressful Situations (CISS)

CISS is a self-report measure adapted from Calsbeek's original scale (30). This 21-item instrument assesses three primary coping styles: problem-focused (7 items), emotion-focused (7 items), and avoidance (7 items). Each style is further divided into seven subcategories. Responses to the items are rated on a 5-point Likert scale ranging from 1 (very little) to 5 (very much) (30). The Persian version of CISS demonstrated acceptable reliability with a Cronbach's alpha coefficient of 0.82 (31). The Persian version of the questionnaire was validated by a panel of ten experts, with a content validity ratio

Table 1: Summary of dialectical behavior therapy (DBT) sessions

Sessions	Session Objective
1	Initial introduction, explanation of session objectives, number of sessions, regular attendance, session duration, mutual introduction of members, general introduction to dialectical behavior therapy and mindfulness, and pre-test administration.
2	Introduction to presenting new coping thoughts and self-affirming self-talk, new coping strategies, and assignment of homework for the next session.
3	Teaching distress tolerance and crisis survival strategies including: distraction from self-harm behavior, distraction through counting and thoughts, daily tasks and activities, pleasurable activities, leaving the situation, and self-soothing with the five senses
4	Introduction to the three states of mind: wise mind, emotional mind, and rational or wise mind.
5	Teaching being in the present moment and mindful awareness in daily life, and mindful communication with others, and teaching effective task completion.
6	Teaching emotion labeling and overcoming obstacles to healthy emotions, and teaching the separation of thoughts and emotions.
7	Teaching balance between thoughts and feelings, and identifying self-harm behaviors, and increasing positive emotions.
8	Teaching passive behavior versus aggressive behavior regarding wants, identifying one's own desires versus one's spouse's desires, and practicing should-thinking.
9	Teaching assertiveness skills and saying no, assertive listening, and obstacles to listening and how to negotiate.

Table 2: Summary of resilient dialectical behavior therapy (RDBT) sessions

Sessions	Session Objective
1	Teaching the weaknesses of supportive and emotional behaviors in the context of marital burnout
2	Treating negative behavioral outbursts stemming from marital burnout
3	Teaching conflictual interactions in the context of marital burnout
4	Treating behavioral and interpersonal tension and anxiety related to marital burnout
5	Treating scattered and problematic thoughts arising from marital burnout
6	Teaching dysfunctional cognitive processing during experiences related to marital burnout
7	Continuing treatment of dysfunctional cognitive problems in the context of marital burnout
8	Treating internal autonomic reactions related to marital burnout
9	Treating scattered bodily reactions related to marital burnout and summarizing and reviewing techniques from previous sessions

(CVR) of 0.94 and a content validity index (CVI) of 0.93 (31). The study exhibited robust internal consistency, with a Cronbach's alpha of 0.80.

2.3.2. The Connor-Davidson Resilience Scale (CD-RISC)

Developed by Connor and Davidson (32), this scale is designed to measure an individual's ability to cope with stress and adversity. Comprising 25 items, the scale is a multidimensional tool with five subscales: personal competence, self-reliance/acceptance of negative affect, positive acceptance, change/safe relationships, and control/spiritual influences. Scoring is based on a 5-point Likert scale ranging from 0 (completely false) to 4 (always true). The scale provides a total score, with a minimum of 0 and a maximum of 100. The average score is typically around 52. Higher scores indicate greater resilience, while scores closer to zero suggest lower resilience. CD-RISC has demonstrated adequate internal consistency in previous studies, as evidenced by a Cronbach's alpha coefficient of 0.77 (17). Keyhani and co-workers (33) validated the Resilience Scale, demonstrating a CVI of 0.97 and a CVR of 0.95. The internal consistency of the measures was high, as indicated by a Cronbach's alpha of 0.83.

2.4. Data Analysis

Data analysis was performed using SPSS version 27. The Shapiro-Wilk test was employed to assess the normality of variable distributions at pre-test and post-test. Levene's test was used to evaluate homogeneity of variances, while Mauchly's test was applied to examine sphericity. Repeated measures ANOVA was conducted to analyze the data, followed by Bonferroni post-hoc tests to compare mean scores between the experimental and control groups at each measurement point.

3. Results

Demographic characteristics revealed that the mean age in the DBT group was 40.27±8.62 years, in the RDBT group: 39.42±6.70 years, and in the control group: 41.93±7.25 years. There was no significant difference in the mean age among the three experimental and control groups (P=0.333). Most participants in the treatment groups had a high school education. In the DBT group, 14 participants (93.3%) were housewives and 1 (6.7%) was employed. In both the RDBT and control groups, all participants were housewives. Regarding the duration of marriage, most participants in all three study groups had been married for 6-10 years. Additionally, in terms of the number of children, most participants in all three study groups had two children. Based on the chi-square test, there was no significant difference between the number of participants in terms of education level, employment status, duration of marriage, and number of children among the three groups (Table 3).

Table 4 presents the descriptive statistics of the study variables for the intervention and control groups. At post-test, the RDBT group demonstrated significantly higher levels of problem-focused coping (mean=29.87, SD=2.47) compared with the DBT (mean=20.60, SD=4.64) and control groups (mean=12.67, SD=2.35). Conversely, the DBT and RDBT groups exhibited significantly lower levels of emotion-focused coping (mean=21.93, SD=3.84 and mean=17.00, SD=2.33, respectively) and avoidant coping (mean=18.87, SD=2.75 and mean=16.80, SD=2.85, respectively) compared with the control group (mean=26.94, SD=2.05 and mean=25.13, SD=2.61, respectively). Moreover, both the DBT and RDBT groups demonstrated significantly higher levels of resilience (mean=63.80, SD=9.80 and mean=68.00, SD=4.40, respectively) compared with the control group (mean=31.70, SD=8.21).

Repeated measures ANOVA revealed a significant difference in the mean scores for problem-focused, emotion-focused, and avoidant coping strategies, and resilience across the

Table 3: Demographic variables of the participants

Groups	Mean±SD age (years)	Duration of marriage (years)	Education	
			High school education	College education
DBT	40.27±8.62	8.55±3.16	9 (60.00%)	6 (40.00%)
RDBT	39.42±6.70	7.83±3.22	10 (66.67%)	5 (33.33%)
Control	41.93±7.25	9.26±3.65	8 (53.33%)	7 (46.67%)
P	0.333	0.265	0.758	

DBT: Dialectical Behavior Therapy; RDBT: Resilient Dialectical Behavior Therapy; SD: Standard Deviation

Table 4: Descriptive statistics of coping strategies and resilience

Variable	Stage	DBT group	RDBT group	Control group	P (between group)
		Mean±SD	Mean±SD	Mean±SD	
Problem-focused coping	Pre-test	13.40±2.66	13.07±1.90	11.73±2.43	0.083
	Post-test	20.60±4.64	29.87±2.47	12.67±2.35	0.001
	Follow-up	19.27±3.39	27.93±2.53	12.67±3.81	0.001
	P (within group)	0.001	0.001	0.427	-
Emotion-focused coping	Pre-test	28.47±2.23	27.47±1.95	27.13±1.99	0.094
	Post-test	21.93±3.84	17.00±2.33	26.94±2.05	0.001
	Follow-up	23.47±3.06	15.20±2.20	27.66±2.02	0.001
	P (within group)	0.001	0.001	0.799	-
Avoidant coping	Pre-test	26.80±3.33	27.93±2.83	25.80±2.48	0.359
	Post-test	18.87±2.75	16.80±2.85	25.13±2.61	0.001
	Follow-up	20.20±3.44	15.93±1.30	27.07±3.86	0.001
	P (within group)	0.001	0.001	0.118	-
Resilience	Pre-test	32.66±7.95	34.87±5.69	33.25±6.28	0.823
	Post-test	63.80±9.80	68.00±4.40	31.70±8.21	0.001
	Follow-up	57.07±9.79	75.40±7.23	30.80±9.64	0.001
	P (within group)	0.001	0.001	0.417	-

DBT: Dialectical Behavior Therapy; RDBT: Resilient Dialectical Behavior Therapy; SD: Standard Deviation

study stages (P=0.001). Additionally, there was a significant interaction effect between time and group membership for coping strategies and resilience (P=0.001). In other words, there were significant differences in the mean scores for problem-focused, emotion-focused, and avoidant coping strategies, and resilience across the three stages (pre-test, post-test, and follow-up) in the study sample. Furthermore, there were significant differences in the mean scores for these strategies and resilience across the three stages of the study in the three groups, indicating that the pattern of change in scores over the pre-test, post-test, and follow-up stages differed significantly across the three groups. Moreover, there were significant differences in the mean scores for problem-focused, emotion-focused, and avoidant coping strategies, and resilience between the DBT, RDBT, and control groups (P=0.001).

The results of the Bonferroni post hoc test to examine the differences between the research groups at the post-test and follow-up stages are presented in Table 5. As can be seen, at both the post-test and follow-up stages, there were significant differences in the mean scores for problem-focused, emotion-focused, and avoidant coping strategies, and resilience between the control group and both the DBT and RDBT groups (P=0.001). When comparing the two treatment methods at the post-test stage, the results showed that DBT and RDBT differed significantly in all three coping strategies (P=0.001). However, in the resilience variable, the results showed that DBT and RDBT did not differ significantly at the post-test stage. But in the resilience variable at the follow-up stage, there was a significant difference between DBT and RDBT groups (P=0.001).

4. Discussion

This study aimed to compare the efficacy of DBT and RDBT in enhancing coping strategies and resilience among women experiencing marital burnout. Findings revealed that both interventions significantly improved coping mechanisms and resilience. Post hoc analyses using the Bonferroni correction indicated that RDBT was more effective in enhancing coping strategies. Although limited research exists on RDBT due to its recent development, the current findings aligned with previous studies (34, 35), thereby contributing to the growing body of literature on therapeutic interventions for marital burnout.

DBT is an approach that uses emotion regulation strategies to address emotional and behavioral problems, with a therapeutic focus on skill training in acceptance and validation (23). In DBT, women with marital burnout were taught to cope with their problems by increasing psychological acceptance and mindfulness of internal experiences such as thoughts and feelings encountered during interactions with their spouses, rather than engaging in cognitive and behavioral avoidance of anxiety-provoking social situations (25). Overall,

Table 5: Bonferroni post hoc test results for pairwise comparisons of mean scores on study variables at post-test and follow-up stages

Variable	Stage	Groups	Mean difference	SE	P
Problem-focused coping	Post-test	Control - DBT	7.93	1.21	0.001
		Control - RDBT	17.20	1.21	0.001
		DBT - RDBT	9.27	1.21	0.001
	Follow-up	Control - DBT	6.60	1.12	0.001
		Control - RDBT	15.27	1.12	0.001
		DBT - RDBT	8.67	1.12	0.001
Emotion-focused coping	Post-test	Control - DBT	-5.00	1.04	0.001
		Control - RDBT	-9.93	1.04	0.001
		DBT - RDBT	-4.93	1.04	0.001
	Follow-up	Control - DBT	-4.20	0.82	0.001
		Control - RDBT	-12.47	0.82	0.001
		DBT - RDBT	-8.27	0.82	0.001
Avoidant coping	Post-test	Control - DBT	-4.27	1.01	0.001
		Control - RDBT	-6.33	1.01	0.001
		DBT - RDBT	-2.07	1.01	0.041
	Follow-up	Control - DBT	-6.87	1.11	0.001
		Control - RDBT	-11.13	1.11	0.001
		DBT - RDBT	-4.27	1.11	0.001
Resilience	Post-test	Control - DBT	32.00	3.49	0.001
		Control - RDBT	36.20	3.49	0.001
		DBT - RDBT	-4.20	3.46	0.235
	Follow-up	Control - DBT	26.27	4.02	0.001
		Control - RDBT	44.60	4.02	0.001
		DBT - RDBT	18.33	4.02	0.001

DBT: Dialectical Behavior Therapy; RDBT: Resilient Dialectical Behavior Therapy; SE: Standard Error

the dynamic and effective confrontation of thoughts and emotions, avoidance of avoidance, techniques focused on distress tolerance, emotion regulation, and interpersonal effectiveness skills led to the learning of effective coping styles for women experiencing marital burnout. On the other hand, resilience is considered a dynamic process of resisting or recovering from significant challenges that threaten the growth and vitality of life (34). Based on this, the components present in the resilience program enable women with marital burnout to establish better social relationships with their spouses (35). Therefore, their stress coping skills and social skills improve, allowing them to manage their lives better and overcome challenges. In other words, resilience plays a protective role in women with marital burnout as it reduces the stressfulness of events and increases coping abilities (17).

Overall, the training programs led to an increased use of problem-focused coping responses and certain cognitive strategies centered on planning, reviewing, and reevaluating, positively influencing emotion regulation. These trainings resulted in a sustained decrease in the use of emotion-focused coping responses and cognitive strategies such as self-blame, rumination, and catastrophizing in emotion regulation. In general, it can be said that this integrated package, with the help of DBT, assists women with marital burnout to harmonize their incongruities (35). These contradictions, although seemingly incompatible, are the focus of treatment to reduce the suffering of individuals struggling with emotional problems. To achieve this goal, skills such as distress tolerance, mindfulness, emotion regulation, and effective communication are taught to individuals (22).

When couples lack DBT skills, they resort to ineffective and unhealthy reactions, employ poor coping strategies, and experience significant distress. This therapy enables women with marital burnout to treat themselves with more kindness and compassion, develop a realistic and accurate perspective on life, make wise decisions, and ultimately cope better with pain and cease self-harming behaviors (35). On the other hand, resilience interventions, through cognitive-emotional regulation training, assist individuals in reconstructing thought patterns through cognitive restructuring. Consequently, the selection of

effective coping strategies in cognitive, emotional, and behavioral dimensions impacts the increased use of adaptive coping mechanisms (15). Overall, teaching optimism enables individuals to employ more problem-focused strategies in stressful situations. When problem-focused coping is not feasible, women with marital burnout use strategies such as acceptance, humor, and positive reframing. Therefore, given that both approaches effectively influence coping strategies, it is evident that a combination of the two would yield more effective results (18).

The study results also indicated that the integrated package of RDBT had a greater effect on the resilience of women with marital burnout compared with DBT alone. The findings of this study were consistent with the results of studies conducted previously (36, 37).

To explain this finding, it can be said that RDBT consists of four fundamental skills of DBT, including distress tolerance, mindfulness, emotion regulation, and interpersonal effectiveness. The skill of interpersonal effectiveness in this package aims to express beliefs, needs, and problem-solving in interpersonal relationships to prevent interpersonal disruptions and promote respectful interactions with others (36). The integrated package also includes teachings from resilience interventions. Having resilience in a family creates a protective environment where family members actively participate in physical, emotional, and psychological well-being, minimizing threats to family growth and health (25).

Resilient individuals are capable of planning to acquire skills such as conversation, assertiveness, listening, and respecting others' feelings and opinions. Furthermore, resilience protects individuals from stress, leading to the moderation of negative effects in marital life (14). Thus, this integrated package, due to the presence of DBT, has a clear structure. Moreover, since this therapy is based on acceptance and change, women with marital burnout, based on this integrated package, come to accept their emotional problems, and ultimately this acceptance facilitates change. Additionally, by combining mindfulness exercises with behavioral exercises, this package allows women with marital burnout to be in a non-judgmental state, accept their emotional states, and try to accept the existence of these states and tolerate them (36). Ultimately, it teaches them mechanisms for transitioning from this state. Through teaching interpersonal communication, a couple's relationship is expanded, and with increased relationships, marital interactions increase. Resilience helps these women to become more resilient and adaptable to reintegrate into difficult situations (18). This means that resilience in the family domain seeks more beneficial ways to react to events such as arguments during disagreements, allowing couples to adapt to life circumstances and feel empowered during difficult times, thus expanding their marital interactions. Therefore, since the goal of this integrated package is to create a different attitude or relationship with thoughts, feelings, and behaviors, and addresses problems such as cognitive flexibility, better coping strategies, and resilience, which women with marital burnout face, it has been more effective than DBT alone in promoting resilience (36).

4.1. Limitations

A limitation of this study was that it was conducted with women experiencing marital burnout specifically in Isfahan, Iran. While this provided a focused sample, it may limit the generalizability of the findings to other regions and cities. A two-month follow-up period, while providing valuable information on the immediate effects of the interventions, may be insufficient to assess long-term outcomes and the sustainability of the changes observed. One of the challenges encountered during the study was the potential for participant attrition due to the sensitive nature of the topic and the emotional demands of the interventions. Despite efforts to maintain participant engagement, some women may have found it difficult to continue with the therapy sessions. The reliance on self-report measures, such as the CISS and CD-RISC, may be subject to biases like social desirability bias or recall bias. Objective measures or mixed-methods approaches could provide additional insights. Additionally, operational constraints such as resource limitations and participant availability could have influenced the sample size and diversity.

5. Conclusions

The findings of this study demonstrated the efficacy of both RDBT and DBT in enhancing coping strategies and resilience among women

experiencing marital burnout. Notably, RDBT exhibited a more pronounced effect in improving these outcomes. These results underscored the potential of psychotherapeutic interventions in addressing the psychological challenges associated with marital distress. Further research is warranted to explore the long-term effects of these interventions and to identify potential moderators or mediators of treatment outcomes. Additionally, investigating the applicability of these findings to diverse populations and cultural contexts would contribute to a more comprehensive understanding of the effectiveness of RDBT and DBT in treating marital burnout.

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Authors' Contribution

Maryam Shirani Nazhvani: Substantial contributions to the conception and design of the work; the acquisition, analysis, and interpretation of data for the work, drafting the work. Felor Khayatan: Substantial contributions to the conception and design of the work; the acquisition, analysis, and interpretation of data for the work, drafting the work and reviewing it critically for important intellectual content. Hadi Farhadi: Substantial contributions to the design of the work, drafting the work and reviewing it critically for important intellectual content. All authors have read and approved the final manuscript and agree to be accountable for all aspects of the work, such that the questions related to the accuracy or integrity of any part of the work.

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Ethical Approval

The study was approved by the Ethical Committee of Islamic Azad University-Isfahan (Khorasgan) Branch, Isfahan, Iran with the code of IR.IAU.KHUISF.REC.1401.137. Also, written informed consent was obtained from the participants.

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