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Comparison of the Effectiveness of Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy on Dysfunctional Beliefs, (Cognitive/Experiential) Avoidance, Conflict Resolution, and Sexual Satisfaction in Infertile Couples

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A B S T R A C T

Objective: This study aimed to compare the effectiveness of Acceptance and Commitment–Based Couple Therapy (ACT-C) and Integrative Couple Therapy (IBCT) on dysfunctional relationship beliefs, cognitive and experiential avoidance, conflict resolution styles, and sexual satisfaction in infertile couples.

Methods and Materials: Using a quasi-experimental pretest–posttest–follow-up design with a control group, infertile couples were recruited through purposive sampling and randomly assigned to ACT-C, IBCT, or a waitlist control. Both interventions were delivered in twelve 90-minute sessions across three months. Standardized self-report measures assessed dysfunctional relationship beliefs, cognitive and experiential avoidance, conflict resolution styles, and sexual satisfaction at pretest, posttest, and three-month follow-up. Data were analyzed using repeated-measures analysis of variance, followed by Bonferroni post hoc comparisons to examine within- and between-group differences over time.

Findings: Repeated-measures analyses revealed significant group × time interaction effects for dysfunctional beliefs (total score and selected components), experiential avoidance, and conflict resolution dimensions, indicating differential change trajectories across groups ($p < .05$). ACT-C produced significantly greater reductions than IBCT in belief in the destructiveness of disagreement, belief in spouse unchangeability, total dysfunctional beliefs, and experiential avoidance ($p < .05$). ACT-C also led to greater improvements in positive problem solving and greater reductions in withdrawal and compliance compared with IBCT ($p < .05$). No significant between-group differences were found for cognitive avoidance. Both ACT-C and IBCT demonstrated significant improvements over time relative to the control group on sexual satisfaction components and total score; however, between-therapy differences on sexual satisfaction were not statistically significant ($p > .05$). Treatment gains were largely maintained at follow-up.

Conclusion: Both ACT-C and IBCT are effective interventions for improving relational and sexual outcomes in infertile couples, with ACT-C showing incremental advantages on experiential avoidance, specific dysfunctional beliefs, and key conflict resolution styles, suggesting added value of flexibility-focused processes in this population.

Keywords: *Acceptance and commitment couple therapy; integrative couple therapy; dysfunctional beliefs; cognitive avoidance; experiential avoidance; conflict resolution; sexual satisfaction; infertile couples.*

1. Introduction

Infertility is increasingly conceptualized as a biopsychosocial stressor that extends well beyond reproductive functioning and can permeate identity, intimate life, and relational stability. Contemporary literature describes infertility as a chronic, cyclical condition marked by repeated uncertainty, ambiguous loss, and ongoing exposure to medical procedures, which can intensify psychological distress and couple-level strain (Greil et al., 2010; Pasch & Sullivan, 2017; Rooney & Domar, 2018). Empirical studies have linked infertility-related stress to reductions in quality of life and well-being at the dyadic level, emphasizing that infertility is commonly experienced "as a couple's problem" rather than solely an individual difficulty (Ngai & Loke, 2022; Pásztor et al., 2019). In addition to emotional burden, infertility may be associated with broader health risks and long-term outcomes, which highlights the importance of comprehensive psychosocial care alongside medical treatment (Wang et al., 2022). Within this context, stigma and maladaptive cognitions about parenthood can become salient, particularly when cultural meanings of fertility amplify self-blame, shame, or perceptions of inadequacy (Grunberg et al., 2022; Tang et al., 2024). Qualitative and clinical observations further suggest that women undergoing infertility treatment may experience intensified emotional reactivity around critical treatment milestones, with complex representations of the embryo and heightened vulnerability during the waiting period for pregnancy testing (Sahiner & Boz, 2022). Consistent with these perspectives, infertility counseling and couple-focused interventions are increasingly recommended to address the relational and sexual sequelae of infertility and to mitigate the spillover from treatment-related stress into the marital system (Azar et al., 2024; Mokhtari Serkhani et al., 2021).

A central pathway through which infertility exerts relational harm is the escalation of marital conflict and the activation of dysfunctional relationship beliefs, which may rigidify interaction patterns and reduce constructive problem solving. Family and relationship research consistently shows that conflict topics and conflict processes shape relationship dynamics and satisfaction, and that chronic, unresolved conflict can erode intimacy and dyadic adjustment (Dong et al., 2022; Meyer & Sledge, 2021). In early marital years, conflict resolution styles such as withdrawal, engagement, and compliance have been associated with marital satisfaction across genders, suggesting that how couples manage disagreements may be as important as the content of disagreements (Adriani & Ratnasari, 2021; Kurdek, 1994). In infertility contexts, conflict may be compounded by treatment costs, role strain, perceived inequities, and sexual performance pressures, making conflict management a clinically relevant target (Azar et al., 2024; Pasch & Sullivan, 2017). Cognitive vulnerabilities also appear to play a notable role. Dysfunctional attitudes and irrational beliefs have been documented among infertile women and are responsive to psychological intervention, indicating that belief-level change may be feasible and meaningful for improving adaptation to infertility (Diehimi et al., 2019; Tang et al., 2024). In Iranian and other non-Western contexts, studies have similarly emphasized the role of irrational beliefs and maladaptive cognitions in marital conflict and relational dissatisfaction, supporting the clinical rationale for targeting belief systems in couple interventions (Rabiei et al., 2023; Taghavi Soreh Barq & Mahdizadeh, 2022). Measurement traditions also support this emphasis: communication/relationship beliefs scales have been developed and adapted for Persian-speaking populations, providing a structured framework for assessing belief-based vulnerabilities in marital relationships (Mazaheri & Pour Etemad, 2001). Alongside conflict processes, marital intimacy and satisfaction have been shown to covary with mindfulness, perceived support, and constructive conflict resolution patterns, further indicating that multi-component relational functioning is relevant when designing interventions for distressed couples facing infertility (Mahmoudpour et al., 2020; Rouhanai, 2022).

Sexual well-being is another domain that is frequently compromised in infertility and may, in turn, amplify

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relational distress. The psychological and sexual impact of infertility can manifest as reduced sexual desire, avoidance of sexual contact, diminished sexual satisfaction, and increased performance anxiety, with potential bidirectional links between distress and sexual functioning (Azar et al., 2024; Selmasi et al., 2022). Dyadic research indicates that infertility-related stress is meaningfully associated with sexual satisfaction when examined at the couple level, underscoring the need for interventions that address both partners' experiences rather than focusing on one partner alone (Nakić Radoš et al., 2022). Sexual satisfaction itself is a multi-determined construct influenced by communication, relational stability, and self-evaluative processes, and longitudinal evidence suggests that early relationship factors and self-esteem can shape sexual satisfaction trajectories (Hicks et al., 2021; Larson et al., 1998). Moreover, clinical accounts emphasize that infertility can create a "medicalized sexuality," in which timed intercourse and treatment demands reduce spontaneity and erotic meaning; thus, sex therapy for couples facing infertility often requires an intersystem perspective integrating sexual, relational, and medical subsystems (Oehler et al., 2021). Because sexual satisfaction and marital adjustment are reciprocally linked, interventions that strengthen intimacy, improve conflict resolution, and reduce avoidance may plausibly improve sexual well-being even when infertility-related stress persists (Behbahani & Ghorban Shiroudi, 2020; Fredriksen & et al., 2015). These observations align with the broader couple-therapy literature, which identifies intimacy, sexual functioning, and dyadic coping as key outcomes and mechanisms in relationship interventions (Snyder et al., 2019; Snyder & Balderrama-durbin, 2022).

From a contextual-behavioral perspective, psychological inflexibility and avoidance-based coping are particularly relevant mechanisms in infertility-related distress and couple dysfunction. Experiential avoidance—efforts to escape or control unwanted internal experiences—has been associated with depressive symptoms and infertility-related stress, suggesting that avoidance may mediate the relationship between infertility stressors and emotional outcomes (Galhardo et al., 2020). At the process level, Acceptance and Commitment Therapy (ACT) targets psychological flexibility through acceptance, mindfulness, values-based action, and defusion from rigid cognitions, offering a coherent framework for modifying avoidance and belief-driven behavior within intimate relationships (Hayes et al., 2011; Ong & Eustis, 2021). In anxiety and related conditions, experiential avoidance and safety behaviors are linked to symptom maintenance, and process models emphasize avoidance as a transdiagnostic pathway influencing persistence and relapse of fear and avoidance patterns (Kirk et al., 2019; Smith et al., 2020). Similar process dynamics can be anticipated in infertility, where attempts to control distressing thoughts about parenthood, stigma, or marital adequacy may paradoxically intensify distress and fuel conflict cycles (Galhardo et al., 2020; Tang et al., 2024). Cognitive avoidance specifically—strategies such as thought suppression, distraction, or substituting positive thoughts—has also been considered a maladaptive coping style that may reduce short-term distress but undermine long-term adjustment, and ACT-informed interventions have been shown to reduce cognitive avoidance and improve marital satisfaction in samples with marital problems (Faraji et al., 2022; Mohammadian et al., 2021). Because measurement quality is crucial in process-focused research, it is noteworthy that concerns have been raised about discriminant validity for common experiential avoidance measures (e.g., AAQ-II), encouraging more nuanced, multidimensional assessment approaches when evaluating avoidance-related constructs (Tyndall et al., 2019). The Multidimensional Experiential Avoidance Questionnaire provides such coverage, capturing distinct avoidance facets that may differentially relate to relationship functioning and treatment response (Gámez et al., 2011). Beyond infertility, studies have linked experiential avoidance to emotional dysregulation and psychopathology in youth and clinical populations, reinforcing its relevance as a robust, mechanistically meaningful target (Ghasemi Taqab et al., 2022; Seçer & Ulaş, 2021). In sexual functioning research, psychological inflexibility and mindfulness-related processes have been associated with hypersexuality and sexual satisfaction, suggesting that flexibility processes may also shape sexual outcomes—an implication that is clinically pertinent for infertile couples struggling with sexual concerns (Ong & Eustis, 2021; Ortega-Otero et al., 2023). Additionally, shame and trauma-related intrusions—often intensified by stigma—can contribute to cognitive-affective vulnerability, which may further heighten avoidance and relational withdrawal in infertility contexts (Bortolon & Raffard, 2019; Tang et al., 2024).

Couple-based interventions grounded in ACT and integrative behavioral traditions offer promising avenues to address these intertwined processes of dysfunctional beliefs, avoidance, conflict management, and sexual satisfaction. ACT has been adapted for couples with an emphasis on

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acceptance, values alignment, and flexible responding within relational contexts, and systematic reviews have reported growing evidence for ACT-informed couple interventions across outcomes and populations (Barbosa et al., 2024; Barraca et al., 2024). Clinical and applied studies also support ACT's relevance to couple outcomes such as marital satisfaction, conflict resolution styles, and sexual variables, indicating that ACT processes may generalize to dyadic functioning and intimate life (Behbahani & Ghorban Shiroudi, 2020; Dideh Dar et al., 2021). In infertility-specific work, ACT-based counseling and couple therapy have demonstrated beneficial effects on mental health and quality of life and have been linked to improvements in sexual satisfaction and intimacy, suggesting that process-based interventions can address both distress and relational outcomes in this population (Hossein Panahi & Mir Khafordvand, 2020; Jan Ali Pour Chenaroudkhani, 2023). More recent infertility-focused findings have further highlighted ACT-based couple therapy as a potentially effective approach for enhancing partners' understanding, modifying approach–avoidance patterns, and improving sexual satisfaction among infertile couples, reinforcing the clinical rationale for ACT-C in infertility contexts (Ahmadi, 2025). Parallel lines of research demonstrate that ACT-based interventions can improve sexual functioning and sexual self-efficacy in couples, underscoring ACT's utility for sexual outcomes that are often central to infertility-related distress (Aghighi, 2023). At the same time, integrative couple therapy approaches—particularly Integrative Behavioral Couple Therapy (IBCT)—have a substantial evidence base emphasizing acceptance-based strategies combined with behavior change methods, and have shown efficacy relative to traditional behavioral couple therapy in chronically distressed couples (Briggs et al., 2015; Christensen et al., 2004). Theoretical and clinical frameworks for IBCT and integrative couple therapy highlight the role of emotional acceptance, unified detachment, and behavior shaping, which directly map onto the goals of reducing escalatory conflict patterns and increasing constructive interaction (Christensen & Doss, 2017; Lebow, 2015). Preventive and applied IBCT-based programs have also targeted conflict prevention and have shown feasibility in non-clinical couples, suggesting that integrative models can be flexibly delivered across contexts (Barraca et al., 2021). Meta-analytic evidence indicates that integrative approaches can be effective and that comparative effects versus other modalities (e.g., emotion-focused therapy) may vary by outcome and population, supporting the need for direct comparative studies in specific high-stress contexts such as infertility (Pintea et al., 2019; Snyder & Balderrama-durbin, 2022). Within Iranian samples, integrative behavioral couple therapy has been evaluated with infertile couples and found beneficial for infertility self-efficacy, dyadic adjustment, and sexual satisfaction, suggesting cultural transportability of integrative behavioral principles (Vaziri Nia et al., 2021; Vazirnia et al., 2021). Additional Iranian studies have reported positive effects of integrative couple therapy on marital relationship quality and emotion regulation and on dysfunctional attitudes, which converges with the premise that integrative approaches can modify both interactional and cognitive components of relationship distress (Mousavi Diva et al., 2023; Taghavi Soreh Barq & Mahdizadeh, 2022). Comparative studies have also examined ACT-based couple therapy against compassion-based or integrative models for infertility-related marital conflicts and sexual intimacy, further implying that differential mechanisms may yield distinct outcome profiles (Hasani & Parandin, 2022; Mousavi Haghighi et al., 2022). Because alliance processes and rupture–repair cycles can influence outcomes in contextual therapies, attention to therapeutic alliance and relational repair within ACT delivery may be especially important when couples present with entrenched conflict and infertility-related blame or withdrawal (Walser & O'Connell, 2023). Finally, emerging work in adjacent domains (e.g., adolescent rumination and cognitive avoidance) supports the broader applicability of ACT-related mechanisms to cognitive avoidance processes, reinforcing the transdiagnostic logic for targeting avoidance even when the presenting problem is relational and infertility-related (Pour et al., 2024; Rahimi et al., 2022).

Despite this growing evidence, important gaps remain regarding the comparative effectiveness of ACT-based couple therapy versus integrative couple therapy approaches for core infertility-relevant mechanisms and outcomes. Existing studies often emphasize global distress or marital satisfaction, while fewer investigations simultaneously examine dysfunctional relationship beliefs, both cognitive and experiential avoidance, nuanced conflict resolution styles, and multidimensional sexual satisfaction within a single comparative framework. Given that infertility can activate rigid parenthood cognitions and stigma-related beliefs (Tang et al., 2024), intensify experiential avoidance and maladaptive coping (Galhardo et al., 2020; Kirk et al., 2019), and disrupt sexual intimacy and satisfaction (Azar et al., 2024; Nakić Radoš et al., 2022), an integrated assessment

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of these domains is clinically and theoretically justified. Moreover, because couple therapy outcomes can be shaped by intervention model, mechanisms, and contextual stressors, comparative trials can clarify which approach is better suited for specific targets such as reducing dysfunctional beliefs, decreasing experiential avoidance, improving constructive conflict resolution, and enhancing sexual satisfaction among infertile couples (Barraca et al., 2024; Briggs et al., 2015; Snyder et al., 2019).

The aim of this study was to compare the effectiveness of Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy on dysfunctional beliefs, cognitive and experiential avoidance, conflict resolution, and sexual satisfaction in infertile couples.

2. Methods and Materials

2.1. Study Design and Participants

The research design, considering the objectives and hypotheses, was a quasi-experimental study with a pretest–posttest and follow-up design including a control group. In this design, the effects of the independent variables (Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy) on the dependent variables (dysfunctional beliefs, cognitive/experiential avoidance, conflict resolution, and sexual satisfaction) were examined.

The statistical population of the study consisted of all infertile couples with a definitive diagnosis of infertility who referred to the Infertility Center of Karaj University of Medical Sciences in 2023. Purposive sampling was used to select the study participants. Accordingly, based on the inclusion and exclusion criteria of the study, 45 couples were selected through purposive sampling and were randomly assigned to two experimental groups and one control group (15 couples in the first experimental group, 15 couples in the second experimental group, and 15 couples in the control group).

After sample selection, the Dysfunctional Beliefs Questionnaire, the Cognitive/Experiential Avoidance Questionnaire, the Conflict Resolution Questionnaire, and the Sexual Satisfaction Questionnaire were administered at the pretest stage to participants in the first experimental group, the second experimental group, and the control group. In the next stage, Acceptance and Commitment–Based Couple Therapy was implemented for the first experimental group, and Integrative Couple Therapy was implemented for the second experimental group. The control group was placed on a waiting list and did not receive any psychological intervention until the posttest stage.

At the end of the intervention period, the Dysfunctional Beliefs, Cognitive/Experiential Avoidance, Conflict Resolution, and Sexual Satisfaction questionnaires were again completed by participants in the experimental and control groups at the posttest stage, and a three-month follow-up assessment was conducted to examine the stability of the intervention effects. After completion of the research stages and based on the exclusion criteria, one couple was excluded from the Acceptance and Commitment–Based Couple Therapy group, and data from 14 couples were analyzed. In the Integrative Couple Therapy group, two couples were excluded due to absence from more than two sessions, and data from 13 couples were analyzed; however, all 15 couples in the control group participated in all stages of the study.

The inclusion criteria were as follows: a diagnosis of infertility after at least one year of attempting to conceive, confirmed by a gynecologist or urologist; at least two years of marital life; voluntary consent of both spouses to participate in therapy sessions and to complete questionnaires at three stages (pretest, posttest, and follow-up); no participation in other individual or couple psychotherapy programs during the past six months; absence of severe psychotic disorders, substance dependence, or chronic physical illness that could prevent regular attendance at sessions (based on self-report and preliminary interview); and sufficient literacy skills to understand and respond to the research instruments.

The exclusion criteria included: absence from more than two therapy sessions; willingness to withdraw from the study at any stage of the treatment or assessment process; occurrence of new family, physical, or psychological crises (such as hospitalization, divorce, or bereavement) during the study implementation; and unrealistic or incomplete responses to the questionnaires.

2.2. Measures

Relationship Beliefs Questionnaire by Eidelson and Epstein (1981). This self-report instrument was developed by Eidelson and Epstein in 1981 to assess dysfunctional beliefs in marital relationships. It consists of 40 items and five subscales: belief in the destructiveness of disagreement, belief in the unchangeability of the spouse, belief in mind-reading expectations, belief in sexual perfectionism, and belief in gender differences. Items are scored on a 6-point

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Likert scale ranging from 0 (completely false) to 5 (completely true). Items 1, 6, 11, 16, 21, 26, 31, and 36 assess the belief in the destructiveness of disagreement; items 3, 8, 13, 18, 23, 28, 33, and 38 assess the belief in the unchangeability of the spouse; items 2, 7, 12, 17, 27, 32, and 37 assess the belief in mind-reading expectations; items 4, 9, 14, 19, 24, 29, 34, and 39 assess the belief in sexual perfectionism; and items 5, 10, 15, 20, 25, 30, 35, and 40 assess the belief in gender differences. Higher scores indicate stronger dysfunctional and irrational beliefs in marital relationships. Cronbach's alpha coefficients for the subscales have been reported to range from .72 to .82, and .86 for the total score. The developers also demonstrated positive correlations between this questionnaire and the General Beliefs Questionnaire developed by Jones (1968), indicating convergent validity. The Persian version of this instrument was prepared by Mazaheri and Pour-Etemad (2001) using a translation and back-translation procedure, with a reported Cronbach's alpha of .75. In the present study, Cronbach's alpha for this instrument was .79.

Cognitive Avoidance Questionnaire by Sexton and Dugas (2004). This self-report instrument was developed in 2004 to assess individuals' use of cognitive avoidance strategies. It consists of 25 items and five subscales: thought suppression, positive thought substitution, distraction to interrupt worry, avoidance of worry-triggering situations and activities, and transformation of mental images into verbal thoughts. Items are scored on a 5-point Likert scale ranging from 1 (completely false) to 5 (completely true). Items 1, 2, 5, 6, and 14 assess thought suppression; items 4, 11, 17, 20, and 25 assess positive thought substitution; items 8, 10, 12, 13, and 21 assess distraction to interrupt worry; items 7, 9, 16, 18, and 22 assess avoidance of worry-triggering situations and activities; and items 3, 15, 19, 23, and 24 assess transformation of mental images into verbal thoughts. The validity coefficient of this instrument, obtained through correlation with the White Bear Suppression Inventory, was reported as .48 and was significant at the .01 level. The developers reported a Cronbach's alpha of .91 for the total scale and coefficients ranging from .71 to .90 for the subscales. In a study by Basak-Nejad et al. (2010), the validity and reliability of this questionnaire were also confirmed, with a Cronbach's alpha of .91 for the total scale and coefficients ranging from .71 to .89 for the subscales (as cited in Mahmoudpour et al., 2021). Mahmoudpour et al. (2021) reported a Cronbach's alpha of .69 for this instrument. In the present study, Cronbach's alpha was .85.

Experiential Avoidance Questionnaire by Gams et al. (2011). This questionnaire was developed by Gams et al. in 2011 and consists of 62 items assessing six subscales: behavioral avoidance (items 1, 8, 14, 20, 26, 32, 39, 45, 51, 55, 59), maladaptive distress (items 2, 7, 13, 19, 25, 31, 34, 38, 44, 50, 54, 48, 61), procrastination (items 5, 11, 17, 36, 42, 47), distraction/suppression (items 3, 9, 15, 22, 27, 33, 40), denial/suppression (items 4, 10, 16, 21, 23, 28, 35, 41, 46, 49, 52, 56, 60), and distress tolerance (items 6, 12, 18, 24, 29, 37, 43, 48, 53, 57, 62). Responses are scored on a 6-point Likert scale ranging from 0 (strongly disagree) to 5 (strongly agree). Items 23 and 30 are reverse scored. Gams et al. (2011) reported Cronbach's alpha coefficients ranging from .91 to .95 across different samples and a correlation of .74 with the Acceptance and Action Questionnaire as evidence of convergent validity. In the present study, Cronbach's alpha coefficients for the subscales of behavioral avoidance, maladaptive distress, procrastination, distraction/suppression, denial/suppression, and distress tolerance were .77, .70, .55, .80, .78, and .79, respectively.

Conflict Resolution Styles Questionnaire by Kurdek (1994). This self-report instrument was developed by Kurdek in 1994 to assess individuals' preferred styles of conflict resolution in interpersonal interactions. It consists of 16 items and four subscales: positive problem solving, conflict engagement, withdrawal, and compliance. Items are scored on a 5-point Likert scale ranging from 1 (never) to 5 (always). Items 2, 6, 10, and 14 assess positive problem solving; items 1, 5, 9, and 13 assess conflict engagement; items 3, 7, 11, and 15 assess withdrawal; and items 4, 8, 12, and 16 assess compliance. The developer reported a Cronbach's alpha of .90 for the total scale and coefficients ranging from .65 to .86 for the subscales. In a study by Shokri and Matini-Yekta (2019), internal consistency coefficients were .88 for the total scale and ranged from .71 to .87 for the subscales. In the present study, Cronbach's alpha was .81.

Sexual Satisfaction Questionnaire by Larson et al. (1998). This self-report instrument was developed by Larson et al. in 1998 to assess sexual satisfaction. It consists of 25 items scored on a 5-point Likert scale ranging from 1 to 5. In items 1, 2, 3, 10, 12, 13, 16, 17, 19, 21, 22, and 23, the response "never" receives a score of 1 and "always" receives a score of 5. In items 4, 5, 6, 7, 8, 9, 11, 14, 15, 18, 20, 24, and 25, the response "always" receives a score of 1 and "never" receives a score of 5. Scores ranging from 25 to 50 indicate sexual dissatisfaction, 51 to 75 indicate low sexual satisfaction, 76 to 100 indicate moderate sexual satisfaction,

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and 101 to 125 indicate high sexual satisfaction. The developers reported test–retest reliability of .90, reliability of .86, and a Cronbach's alpha of .91. In a study by Behbahani and Ghorban Shiroudi (2020), Cronbach's alpha was reported as .89.

2.3. Interventions

Acceptance and Commitment–Based Couple Therapy was delivered to the first experimental group across 12 weekly sessions of 90 minutes over a three-month period. The intervention began with establishing a therapeutic alliance and clarifying expectations, followed by a shared conceptualization of couple distress using experiential metaphors to highlight ineffective control strategies and avoidance patterns. Subsequent sessions emphasized conscious commitment to the relationship, mindful presence in interactions, and cognitive defusion techniques to reduce entanglement with repetitive, judgmental thoughts. Couples were guided to identify and soften unrealistic expectations, clarify individual and shared values, and translate these values into observable, value-consistent behaviors within the relationship. Emotional reconnection was fostered through openness and acceptance, with particular attention to tolerating difficult emotions and reducing experiential avoidance. Later sessions addressed internal barriers such as rigid beliefs, fears, and negative self-talk, as well as external barriers through structured problem-solving strategies. The final sessions integrated all acquired skills under the concept of psychological flexibility, helping couples consolidate learning, plan for maintenance, and commit to ongoing value-guided action in their relational lives.

Integrative Couple Therapy was provided to the second experimental group in 12 weekly 90-minute sessions over three months, following an integrative behavioral framework. Treatment commenced with orientation, alliance building, and the establishment of therapeutic structure and communication rules, followed by individual sessions with each partner to explore relational history, dysfunctional attitudes, emotional avoidance, and confidentiality boundaries. The therapist then offered structured feedback and an initial case formulation, identifying core relational themes and problematic interactional patterns while highlighting relationship strengths and resources. Subsequent sessions focused on analyzing maladaptive interaction cycles, enhancing emotional awareness, and promoting empathic listening through emotion-focused interventions. As therapy progressed, formulations were revised to reflect emerging insights, and acceptance-based strategies were introduced to help partners tolerate negative emotions and reduce reactive patterns during conflict. Behavioral interventions and in-session skill practice targeted communication and positive behavioral exchanges, alongside training in emotional tolerance and self-care. The final phase emphasized generalization of skills to daily life, reflective self-monitoring, consolidation of emotional and behavioral changes, and planning for the maintenance of therapeutic gains beyond treatment termination.

2.4. Data Analysis

Data analysis was conducted using repeated-measures analysis of variance and post hoc tests in SPSS version 26.

3. Findings and Results

In describing the sample groups, the statistical results showed that in the Acceptance and Commitment–Based Couple Therapy group, the mean and standard deviation of female participants' age were 32.71 and 4.65 years, respectively; in the Integrative Couple Therapy group, 31.08 and 3.10 years; and in the control group, 31.73 and 3.04 years.

In addition, in the Acceptance and Commitment–Based Couple Therapy group, the mean and standard deviation of male participants' age were 36.82 and 5.23 years, respectively; in the Integrative Couple Therapy group, 35.18 and 3.40 years; and in the control group, 36.50 and 3.85 years.

Moreover, in the Acceptance and Commitment–Based Couple Therapy group, the mean and standard deviation of the time elapsed since marriage among participating couples were 6.92 and 1.73 years, respectively; in the Integrative Couple Therapy group, 5.07 and 1.66 years; and in the control group, 5.23 and 1.58 years.

Table 1 presents the mean (standard deviation) of the components of dysfunctional beliefs (belief in the destructiveness of disagreement, mind-reading expectation, belief in the unchangeability of the spouse, sexual perfectionism, and belief about gender differences), avoidance (experiential and cognitive), conflict resolution (positive problem solving, conflict engagement, conflict withdrawal, and compliance), and sexual satisfaction (desire to engage in sexual relations, sexual attitude, sexual quality of life, and sexual compatibility) among participants in the study groups across three time points (pretest, posttest, and follow-up).

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Table 1

Means and Standard Deviations of Components and Total Scores of Dysfunctional Beliefs, Avoidance, Conflict Resolution, and Sexual Satisfaction Across Pretest, Posttest, and Follow-Up

Variable	Component	Group	Pretest M (SD)	Posttest M (SD)	Follow-up M (SD)
Dysfunctional beliefs	Destructiveness of disagreement	ACT-based	25.96 (4.94)	18.89 (3.48)	19.60 (3.58)
		Integrative	27.11 (5.21)	21.03 (2.83)	21.15 (3.33)
		Control	26.70 (4.25)	24.73 (3.56)	25.87 (4.65)
Dysfunctional beliefs	Mind-reading expectation	ACT-based	27.46 (6.14)	20.11 (3.86)	21.45 (3.81)
		Integrative	25.54 (4.57)	21.42 (4.53)	22.04 (3.97)
		Control	26.23 (4.91)	25.20 (4.21)	25.53 (3.43)
Dysfunctional beliefs	Unchangeability of spouse	ACT-based	28.50 (5.67)	20.32 (3.58)	20.93 (3.63)
		Integrative	29.34 (5.96)	23.54 (4.36)	23.34 (4.35)
		Control	30.28 (4.62)	28.23 (5.00)	29.37 (4.63)
Dysfunctional beliefs	Sexual perfectionism	ACT-based	19.61 (3.73)	15.75 (2.96)	16.86 (3.35)
		Integrative	20.92 (3.71)	16.03 (3.18)	16.65 (2.99)
		Control	19.30 (3.90)	20.13 (4.15)	19.53 (3.73)
Dysfunctional beliefs	Belief about gender differences	ACT-based	20.29 (3.91)	16.43 (2.60)	16.32 (2.58)
		Integrative	21.81 (3.32)	17.42 (2.83)	17.27 (2.69)
		Control	21.10 (4.06)	19.83 (3.35)	20.23 (2.86)
Dysfunctional beliefs	Total score	ACT-based	121.82 (12.70)	91.50 (8.52)	95.18 (9.38)
		Integrative	124.73 (11.89)	89.46 (8.69)	100.46 (7.83)
		Control	123.60 (12.33)	118.13 (8.67)	120.53 (9.07)
Avoidance	Experiential	ACT-based	182.14 (20.94)	142.03 (14.31)	150.36 (15.37)
		Integrative	178.00 (23.25)	156.54 (15.14)	162.46 (14.23)
		Control	176.50 (19.86)	181.47 (16.74)	179.76 (19.80)
Avoidance	Cognitive	ACT-based	73.07 (8.74)	58.96 (6.62)	60.67 (7.01)
		Integrative	71.65 (7.69)	65.04 (6.12)	63.27 (7.38)
		Control	74.60 (8.93)	76.43 (7.74)	75.90 (7.34)
Conflict resolution	Positive problem solving	ACT-based	9.86 (2.71)	15.29 (2.12)	15.32 (2.60)
		Integrative	10.57 (3.00)	13.60 (2.16)	13.46 (2.67)
		Control	9.53 (2.55)	10.27 (2.54)	9.96 (2.25)
Conflict resolution	Conflict engagement	ACT-based	13.71 (2.91)	10.82 (2.52)	11.07 (1.98)
		Integrative	14.16 (2.54)	11.54 (2.26)	11.34 (2.56)
		Control	14.07 (2.68)	13.77 (2.97)	14.20 (2.41)
Conflict resolution	Conflict withdrawal	ACT-based	13.11 (2.60)	8.68 (1.81)	8.93 (1.86)
		Integrative	13.54 (2.14)	10.83 (2.13)	11.00 (2.06)
		Control	13.80 (2.37)	13.37 (2.65)	13.77 (2.10)
Conflict resolution	Compliance	ACT-based	12.31 (2.26)	8.93 (2.23)	9.89 (2.73)
		Integrative	12.73 (2.55)	10.84 (2.27)	10.77 (2.69)
		Control	13.03 (2.59)	12.43 (2.62)	12.90 (2.02)
Sexual satisfaction	Desire for sexual relations	ACT-based	8.71 (2.17)	13.14 (2.21)	13.32 (2.40)
		Integrative	9.57 (2.04)	11.76 (2.97)	11.62 (2.31)
		Control	9.40 (2.91)	10.03 (2.41)	9.15 (2.56)
Sexual satisfaction	Sexual attitude	ACT-based	13.39 (2.74)	17.10 (2.36)	15.89 (2.55)
		Integrative	14.20 (2.81)	16.04 (2.94)	16.19 (3.12)
		Control	14.23 (2.51)	14.53 (2.60)	13.97 (3.41)
Sexual satisfaction	Sexual quality of life	ACT-based	7.46 (1.95)	10.50 (1.71)	10.39 (2.33)
		Integrative	8.11 (1.98)	10.07 (2.02)	10.23 (2.27)
		Control	7.40 (2.09)	7.93 (1.91)	7.67 (2.00)
Sexual satisfaction	Sexual compatibility	ACT-based	10.96 (2.28)	14.14 (2.25)	13.89 (2.87)
		Integrative	11.42 (2.56)	13.61 (2.30)	12.73 (2.55)
		Control	11.07 (2.31)	11.30 (2.56)	11.76 (2.70)
Sexual satisfaction	Total score	ACT-based	40.54 (6.65)	54.71 (7.39)	53.48 (6.99)
		Integrative	43.31 (7.50)	51.50 (7.10)	50.77 (6.87)
		Control	42.10 (7.01)	43.80 (6.21)	42.47 (7.18)

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Table 1 indicates that, in both experimental groups, the mean scores of the components and the total score of dysfunctional beliefs, experiential and cognitive avoidance, and the conflict resolution factors of conflict engagement, conflict withdrawal, and compliance decreased at posttest and follow-up, while the mean score of positive problem solving (conflict resolution) and the components and total score of sexual satisfaction increased. In contrast, similar changes were not observed in the control group across the same time points.

To test the effectiveness of the independent variables on the dependent variables, repeated-measures analysis of variance was used. First, the assumptions of repeated-measures ANOVA—including normality of the data distribution, homogeneity of error variances, homogeneity of covariance matrices of the dependent variables, and the sphericity assumption—were examined. After evaluating these assumptions and confirming that they were met, the hypotheses were tested using repeated-measures ANOVA.

Table 2

Results of Repeated-Measures Analysis of Variance (RM-ANOVA) for the Effects of the Independent Variables on the Components and Total Scores of Dysfunctional Beliefs, Avoidance, Conflict Resolution, and Sexual Satisfaction

Variable	Component	Effect	Sum of Squares	Error Sum of Squares	F	p	η^2
Dysfunctional beliefs	Destructiveness of disagreement	Group effect	814.67	1231.60	26.79	< .001	.398
		Time effect	804.47	1290.78	50.48	< .001	.384
		Group × Time interaction	330.40	2539.35	5.27	< .001	.115
Dysfunctional beliefs	Mind-reading expectation	Group effect	406.12	1903.98	8.64	< .001	.176
		Time effect	483.87	1823.40	21.50	< .001	.210
		Group × Time interaction	334.35	2890.03	4.69	< .001	.104
Dysfunctional beliefs	Unchangeability of spouse	Group effect	1640.89	1946.85	34.14	< .001	.457
		Time effect	976.47	1720.36	46.07	< .001	.363
		Group × Time interaction	425.76	3372.97	5.11	< .001	.112
Dysfunctional beliefs	Sexual perfectionism	Group effect	246.29	1118.61	8.92	< .001	.180
		Time effect	214.16	959.87	18.07	< .001	.182
		Group × Time interaction	291.65	1962.67	6.02	< .001	.129
Dysfunctional beliefs	Beliefs about gender differences	Group effect	322.45	903.88	14.45	< .001	.263
		Time effect	408.27	898.45	36.81	< .001	.312
		Group × Time interaction	129.74	1572.54	3.34	.012	.076
Dysfunctional beliefs	Total score	Group effect	14788.65	8966.40	66.80	< .001	.623
		Time effect	13567.71	10249.12	107.23	< .001	.570
		Group × Time interaction	6620.27	15662.76	17.12	< .001	.297
Avoidance	Experiential avoidance	Group effect	19906.62	26474.94	30.45	< .001	.429
		Time effect	9027.43	30284.52	24.15	< .001	.230
		Group × Time interaction	16422.36	52539.13	12.66	< .001	.238
Avoidance	Cognitive avoidance	Group effect	6306.59	4384.85	58.25	< .001	.590

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		Time effect	1764.37	4048.57	28.31	< .001	.259
		Group × Time interaction	2248.41	9557.31	9.53	< .001	.190
Conflict resolution	Positive problem solving	Group effect	595.58	488.83	49.34	< .001	.549
		Time effect	358.70	445.49	65.37	< .001	.447
		Group × Time interaction	229.16	10111.88	9.17	< .001	.185
Conflict resolution	Conflict engagement	Group effect	219.79	469.54	19.05	< .001	.320
		Time effect	131.49	524.97	20.29	< .001	.201
		Group × Time interaction	93.66	1123.91	3.38	.011	.077
Conflict resolution	Conflict withdrawal	Group effect	506.41	415.25	49.39	< .001	.549
		Time effect	211.92	318.77	53.85	< .001	.399
		Group × Time interaction	162.47	766.38	8.59	< .001	.175
Conflict resolution	Compliance	Group effect	253.62	592.09	17.35	< .001	.300
		Time effect	95.16	354.64	21.74	< .001	.212
		Group × Time interaction	71.09	866.70	3.32	.012	.076
Sexual satisfaction	Desire for sexual relations	Group effect	213.68	525.40	16.47	< .001	.289
		Time effect	189.24	554.75	27.58	< .001	.254
		Group × Time interaction	187.62	950.14	8.00	< .001	.165
Sexual satisfaction	Sexual attitude	Group effect	85.08	710.77	4.85	.010	.107
		Time effect	83.35	598.43	11.28	< .001	.122
		Group × Time interaction	103.69	184.39	3.55	.007	.080
Sexual satisfaction	Sexual quality of life	Group effect	186.71	244.25	30.96	< .001	.434
		Time effect	131.16	442.19	24.03	< .001	.223
		Group × Time interaction	67.46	765.23	3.57	.008	.081
Sexual satisfaction	Sexual compatibility	Group effect	124.29	473.36	10.63	< .001	.208
		Time effect	113.32	518.85	17.70	< .001	.179
		Group × Time interaction	77.44	892.86	3.19	.015	.073

Table 2 shows that, in addition to the group effect and the time effect, the Group × Time interaction effect was statistically significant for the dysfunctional-beliefs components of belief in the destructiveness of disagreement ($\eta^2 = .115$, $p < .001$, $F = 5.27$), mind-reading expectation ($\eta^2 = .104$, $p < .001$, $F = 4.69$), belief in the unchangeability of the spouse ($\eta^2 = .112$, $p < .001$, $F = 5.11$), sexual perfectionism ($\eta^2 = .129$, $p < .001$, $F = 6.02$), beliefs about gender differences ($\eta^2 = .076$, $p = .012$, $F = 3.34$), and the total dysfunctional-beliefs score ($\eta^2 = .297$, $p < .001$, $F = 17.12$). These findings indicate that implementation of the independent variables produced statistically significant changes in the components and total score of dysfunctional beliefs over time.

Table 2 also shows that the Group × Time interaction effect was statistically significant for experiential avoidance ($\eta^2 = .238$, $p < .001$, $F = 12.66$) and cognitive avoidance ($\eta^2 = .190$, $p < .001$, $F = 9.53$).

Another result in Table 2 indicates that the Group × Time interaction effect was statistically significant for positive

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problem solving (η^2 = .185, p < .001, F = 9.17), conflict engagement (η^2 = .077, p = .011, F = 3.38), conflict withdrawal (η^2 = .175, p < .001, F = 8.59), and compliance (η^2 = .076, p = .012, F = 3.32).

This table further shows that the Group × Time interaction effect was statistically significant for desire for sexual relations (η^2 = .165, p < .001, F = 8.00), sexual attitude (η^2 = .080, p = .007, F = 3.55), sexual quality of life (η^2 = .081, p = .008, F = 3.57), sexual compatibility (η^2 = .073, p = .015, F = 3.19), and the total sexual satisfaction score (η^2 = .153, p < .001, F = 7.31).

Table 3

Bonferroni Post Hoc Test Results for Pairwise Comparisons of the Effects of Groups and Time Points on the Components and Total Scores of Dysfunctional Beliefs, Avoidance, Conflict Resolution, and Sexual Satisfaction

Variable	Comparison	Mean difference	Standard error	p
Destructiveness of disagreement	Pretest vs. Posttest	5.04	0.67	< .001
	Pretest vs. Follow-up	4.38	0.62	< .001
	Posttest vs. Follow-up	-0.65	0.54	.696
Mind-reading expectation	Pretest vs. Posttest	4.17	0.65	< .001
	Pretest vs. Follow-up	3.40	0.73	< .001
	Posttest vs. Follow-up	-0.77	0.57	.542
Unchangeability of spouse	Pretest vs. Posttest	5.35	0.76	< .001
	Pretest vs. Follow-up	4.84	0.71	< .001
	Posttest vs. Follow-up	-0.52	0.64	1.000
Sexual perfectionism	Pretest vs. Posttest	2.64	0.57	< .001
	Pretest vs. Follow-up	2.26	0.53	< .001
	Posttest vs. Follow-up	-0.37	0.51	1.000
Beliefs about gender differences	Pretest vs. Posttest	3.17	0.50	< .001
	Pretest vs. Follow-up	3.12	0.52	< .001
	Posttest vs. Follow-up	-0.05	0.42	1.000
Total dysfunctional beliefs	Pretest vs. Posttest	20.36	1.56	< .001
	Pretest vs. Follow-up	18.00	1.74	< .001
	Posttest vs. Follow-up	-2.36	1.22	.168
Experiential avoidance	Pretest vs. Posttest	18.87	2.98	< .001
	Pretest vs. Follow-up	14.69	3.00	< .001
	Posttest vs. Follow-up	-4.18	2.33	.228
Cognitive avoidance	Pretest vs. Posttest	6.30	1.25	< .001
	Pretest vs. Follow-up	6.49	1.22	< .001
	Posttest vs. Follow-up	0.19	1.09	1.000
Positive problem solving	Pretest vs. Posttest	-3.05	0.43	< .001
	Pretest vs. Follow-up	-2.93	0.36	< .001
	Posttest vs. Follow-up	0.13	0.36	1.000
Conflict engagement	Pretest vs. Posttest	1.94	0.45	< .001
	Pretest vs. Follow-up	1.77	0.39	< .001
	Posttest vs. Follow-up	-0.16	0.37	1.000
Conflict withdrawal	Pretest vs. Posttest	2.52	0.38	< .001
	Pretest vs. Follow-up	2.25	0.31	< .001
	Posttest vs. Follow-up	-0.27	0.32	1.000
Compliance	Pretest vs. Posttest	1.96	0.38	< .001
	Pretest vs. Follow-up	1.51	0.32	< .001
	Posttest vs. Follow-up	-0.45	0.37	.660
Desire for sexual relations	Pretest vs. Posttest	-2.38	0.38	< .001
	Pretest vs. Follow-up	-2.13	0.41	< .001
	Posttest vs. Follow-up	0.26	0.33	1.000
Sexual attitude	Pretest vs. Posttest	-1.93	0.39	< .001
	Pretest vs. Follow-up	-1.41	0.42	.004
	Posttest vs. Follow-up	0.52	0.44	.717
Sexual quality of life	Pretest vs. Posttest	-1.84	0.34	< .001
	Pretest vs. Follow-up	-1.77	0.36	< .001
	Posttest vs. Follow-up	0.07	0.31	1.000
Sexual compatibility	Pretest vs. Posttest	-1.87	0.39	< .001

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	Pretest vs. Follow-up	-1.65	0.39	< .001
	Posttest vs. Follow-up	0.22	0.36	1.000
Total sexual satisfaction	Pretest vs. Posttest	-8.02	1.21	< .001
	Pretest vs. Follow-up	-6.95	1.17	< .001
	Posttest vs. Follow-up	1.07	0.94	.768
Destructiveness of disagreement	ACT-based vs. Integrative	-1.61	0.61	.030
	ACT-based vs. Control	-4.28	0.59	< .001
	Integrative vs. Control	-2.66	0.60	< .001
Mind-reading expectation	ACT-based vs. Integrative	0.01	0.76	1.000
	ACT-based vs. Control	-2.64	0.74	< .001
	Integrative vs. Control	-2.66	0.75	< .001
Unchangeability of spouse	ACT-based vs. Integrative	-2.16	0.77	.019
	ACT-based vs. Control	-6.05	0.74	< .001
	Integrative vs. Control	-3.89	0.76	< .001
Sexual perfectionism	ACT-based vs. Integrative	-0.47	0.58	1.000
	ACT-based vs. Control	-2.25	0.56	< .001
	Integrative vs. Control	-1.78	0.58	.008
Beliefs about gender differences	ACT-based vs. Integrative	-1.16	0.53	.092
	ACT-based vs. Control	-2.71	0.51	< .001
	Integrative vs. Control	-1.56	0.52	.010
Total dysfunctional beliefs	ACT-based vs. Integrative	-5.39	1.65	.005
	ACT-based vs. Control	-17.93	1.60	< .001
	Integrative vs. Control	-12.55	1.63	< .001
Experiential avoidance	ACT-based vs. Integrative	-7.49	2.84	.030
	ACT-based vs. Control	-21.07	2.74	< .001
	Integrative vs. Control	-13.58	2.80	< .001
Cognitive avoidance	ACT-based vs. Integrative	-2.42	1.16	.120
	ACT-based vs. Control	-11.41	1.12	< .001
	Integrative vs. Control	-8.99	1.14	< .001
Positive problem solving	ACT-based vs. Integrative	0.95	0.39	.048
	ACT-based vs. Control	3.57	0.37	< .001
	Integrative vs. Control	2.62	0.38	< .001
Conflict engagement	ACT-based vs. Integrative	-0.48	0.38	.634
	ACT-based vs. Control	-2.14	0.37	< .001
	Integrative vs. Control	-1.67	0.37	< .001
Conflict withdrawal	ACT-based vs. Integrative	-1.56	0.36	< .001
	ACT-based vs. Control	-3.41	0.34	< .001
	Integrative vs. Control	-1.85	0.35	< .001
Compliance	ACT-based vs. Integrative	-1.07	0.43	.042
	ACT-based vs. Control	-2.41	0.41	< .001
	Integrative vs. Control	-1.34	0.42	.006
Desire for sexual relations	ACT-based vs. Integrative	0.70	0.40	.249
	ACT-based vs. Control	2.17	0.39	< .001
	Integrative vs. Control	1.47	0.39	< .001
Sexual attitude	ACT-based vs. Integrative	-0.03	0.47	1.000
	ACT-based vs. Control	1.20	0.45	.028
	Integrative vs. Control	1.23	0.46	.026
Sexual quality of life	ACT-based vs. Integrative	-0.02	0.27	1.000
	ACT-based vs. Control	1.79	0.26	< .001
	Integrative vs. Control	1.81	0.27	< .001
Sexual compatibility	ACT-based vs. Integrative	0.41	0.38	.851
	ACT-based vs. Control	1.62	0.37	< .001
	Integrative vs. Control	1.21	0.37	< .001
Total sexual satisfaction	ACT-based vs. Integrative	1.06	1.03	.919
	ACT-based vs. Control	6.77	0.99	< .001
	Integrative vs. Control	5.72	1.01	< .001

The results in Table 3 showed that the difference between the effects of Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy on the dysfunctional-beliefs components of belief in the destructiveness of disagreement (p = .030), belief in the unchangeability of the spouse (p = .019), and the total

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dysfunctional-beliefs score ($p < .001$) was statistically significant. Specifically, Acceptance and Commitment–Based Couple Therapy, compared with Integrative Couple Therapy, produced greater reductions in these components and in the total dysfunctional-beliefs score. Accordingly, it was concluded that there is a significant difference between the effectiveness of Integrative Couple Therapy and Acceptance and Commitment–Based Couple Therapy in reducing dysfunctional beliefs in infertile couples, with Acceptance and Commitment–Based Couple Therapy being the more effective approach.

The results in Table 3 also showed that the difference between the effects of Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy on experiential avoidance ($p = .030$) was statistically significant, such that Acceptance and Commitment–Based Couple Therapy resulted in a greater reduction in experiential avoidance than Integrative Couple Therapy. It should be noted that the difference between the effects of the two therapeutic approaches on cognitive avoidance was not statistically significant. Accordingly, it was concluded that Acceptance and Commitment–Based Couple Therapy, compared with Integrative Couple Therapy, is a more effective approach for reducing experiential avoidance in infertile couples.

Another finding of the Bonferroni post hoc test in Table 3 indicates that the difference between the effects of Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy on positive problem solving ($p = .048$), conflict withdrawal ($p < .001$), and compliance ($p = .042$) was statistically significant. Specifically, Acceptance and Commitment–Based Couple Therapy, compared with Integrative Couple Therapy, produced greater reductions in the mean scores of conflict withdrawal and compliance and a greater increase in positive problem solving. Accordingly, it was concluded that Acceptance and Commitment–Based Couple Therapy, compared with Integrative Couple Therapy, is a more appropriate approach for improving conflict resolution styles in infertile couples.

The Bonferroni post hoc test results in Table 3 further indicate that the differences between the effects of Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy on none of the components or the total score of sexual satisfaction were statistically significant. Accordingly, it was concluded that there is no statistically significant difference between the effectiveness of Acceptance and Commitment–Based Couple Therapy and Integrative Couple Therapy on sexual satisfaction in infertile couples.

4. Discussion

The present study compared Acceptance and Commitment–Based Couple Therapy (ACT-C) with Integrative Couple Therapy in infertile couples across dysfunctional relationship beliefs, cognitive/experiential avoidance, conflict resolution styles, and sexual satisfaction. Overall, the pattern of findings indicated that both active interventions produced meaningful improvements over time relative to the control condition, while ACT-C demonstrated incremental advantages over integrative couple therapy on several process-proximal targets. Specifically, both experimental groups showed reductions from pretest to posttest that were largely maintained at follow-up in dysfunctional beliefs and avoidance indices, alongside improvements in conflict resolution and sexual satisfaction; however, ACT-C outperformed integrative couple therapy in reducing the dysfunctional-belief components of belief in the destructiveness of disagreement and belief in the unchangeability of the spouse, as well as the total dysfunctional-beliefs score. ACT-C also yielded a greater reduction in experiential avoidance than integrative couple therapy, and demonstrated stronger effects on conflict-resolution profiles by increasing positive problem solving and decreasing withdrawal and compliance. In contrast, the between-therapy difference on cognitive avoidance was not statistically significant, and the two interventions did not differ in their impact on any component or total score of sexual satisfaction, despite both outperforming the control group on sexual satisfaction indices. Interpreting these findings within infertility contexts is clinically important because infertility is repeatedly characterized as a high-burden relational stressor that disrupts emotional security, increases distress, and escalates dyadic strain through uncertainty, stigma, and treatment-related demands (Greil et al., 2010; Pasch & Sullivan, 2017; Rooney & Domar, 2018). Dyadic evidence also indicates that infertility-related stress is linked with sexual satisfaction at the couple level, reinforcing the relevance of couple-based interventions that concurrently address relational processes and sexual outcomes (Nakić Radoš et al., 2022; Selmasi et al., 2022).

The superior impact of ACT-C on targeted dysfunctional beliefs is theoretically coherent with the ACT model's emphasis on psychological flexibility and altered responding to private events rather than direct disputation of content. In

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infertility contexts, rigid, self-referential parenthood cognitions and infertility stigma are associated with maladaptive appraisals and relational vulnerability, which can manifest in absolutistic beliefs about disagreement, responsibility, and partner changeability (Grunberg et al., 2022; Tang et al., 2024). ACT's focus on cognitive defusion, acceptance, values clarification, and committed action can reduce the functional dominance of rigid beliefs, thereby enabling more flexible interpersonal responding during conflict and reducing the perceived threat of disagreement (Hayes et al., 2011; Ong & Eustis, 2021). This mechanism-level interpretation aligns with evidence that ACT-based approaches can improve relational variables such as marital satisfaction and conflict resolution styles in married samples and can reduce irrational beliefs among women experiencing marital conflict (Dideh Dar et al., 2021; Rabiei et al., 2023). It is also consistent with infertility-specific findings indicating ACT-based counseling and couple therapy can improve mental health and quality of life among infertile couples, and with reports of ACT-based couple therapy improving relational understanding and approach–avoidance patterns in infertility (Ahmadi, 2025; Hossein Panahi & Mir Khafordvand, 2020). By comparison, integrative couple therapy—particularly integrative behavioral couple therapy (IBCT)—also incorporates acceptance-oriented work, but the present findings suggest that ACT-C may have provided a more direct, process-consistent pathway for decreasing belief rigidity linked to conflict escalation in this sample. This is not inconsistent with IBCT's demonstrated efficacy in distressed couples, but it underscores that different acceptance-based models may differentially influence belief-related targets depending on emphasis, dosage, and the salience of avoidance processes in the presenting problem (Briggs et al., 2015; Christensen et al., 2004; Christensen & Doss, 2017). Relatedly, Iranian studies showing beneficial effects of integrative couple therapy on dysfunctional attitudes support its effectiveness, yet the current comparative advantage for ACT-C suggests that flexibility-centered processes may be particularly potent for certain belief domains in infertility-related distress (Mousavi Diva et al., 2023; Taghavi Soreh Barq & Mahdizadeh, 2022).

A second key result was that ACT-C reduced experiential avoidance more than integrative couple therapy, while differences between therapies for cognitive avoidance were not significant. This pattern is consistent with the conceptual distinction between experiential avoidance as a core, transdiagnostic process and cognitive avoidance as a strategy subset that may shift under multiple intervention pathways. Experiential avoidance has been empirically implicated in infertility-related distress and depressive symptoms, suggesting it functions as a pathway linking infertility stressors to emotional dysregulation and relational strain (Galhardo et al., 2020). ACT explicitly targets experiential avoidance by cultivating willingness and acceptance, helping clients contact distressing internal experiences without engaging in escape-based behavioral repertoires, and supporting values-based action even under distress (Hayes et al., 2011; Ong & Eustis, 2021). Thus, a larger reduction in experiential avoidance under ACT-C is expected and also accords with findings showing ACT-related interventions can reduce experiential avoidance in other populations and symptom presentations (Ghasemi Taqab et al., 2022; Seçer & Ulaş, 2021). Furthermore, process models in anxiety and avoidance demonstrate that safety behaviors and experiential avoidance maintain threat responding, and ACT-based treatment can reduce relapse of fear and avoidance by shifting the function of internal cues rather than eliminating them, which supports the plausibility of robust avoidance reductions in ACT-C (Kirk et al., 2019; Smith et al., 2020). The non-significant between-therapy difference on cognitive avoidance may reflect that both approaches contain active ingredients that can disrupt cognitive avoidance strategies: ACT through defusion and mindfulness practices, and integrative couple therapy through improved interaction patterns, emotional acceptance, and cognitive-affective reframing within the dyad. Prior evidence indicates ACT-based training can reduce cognitive avoidance and improve marital satisfaction, and ACT delivered to couples has been associated with reductions in cognitive avoidance and improvements in empathy and relational functioning (Faraji et al., 2022; Mohammadian et al., 2021). At the same time, because measurement nuances can influence conclusions about avoidance processes, concerns about the discriminant validity of commonly used experiential avoidance measures underscore the importance of multidimensional assessment when drawing mechanistic inferences (Tyndall et al., 2019). The use of a multidimensional experiential avoidance instrument is therefore a methodological strength for interpreting the present experiential avoidance findings in a process-consistent manner (Gámez et al., 2011).

The conflict resolution findings further indicate that ACT-C conferred incremental benefits on positive problem solving and reductions in withdrawal and compliance relative to integrative couple therapy, while both approaches

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improved conflict engagement relative to control without differing from each other. These outcomes fit with ACT's behavioral emphasis on committed action and values-guided responsiveness, which can translate into more constructive engagement with problems and less reliance on rigid interpersonal strategies such as withdrawal (avoidant disengagement) or compliance (appeasement) when distress is high. In infertility contexts, conflict may be fueled by chronic uncertainty and identity threats, and the perceived stakes of disagreement may increase withdrawal and coercive cycles; thus, interventions that increase flexibility and reduce avoidance should predict improved conflict styles (Grunberg et al., 2022; Pasch & Sullivan, 2017). The present results align with broader evidence that conflict resolution styles are associated with marital satisfaction and that maladaptive conflict patterns can erode relationship functioning, particularly in early relational stages (Adriani & Ratnasari, 2021; Kurdek, 1994). They also accord with findings that ACT can improve conflict resolution styles and marital satisfaction, suggesting that process-based change in flexibility may translate into more adaptive conflict management (Dideh Dar et al., 2021). Integrative couple therapy and IBCT likewise target interactional cycles and emphasize acceptance, unified detachment, and behavior change, and extensive research supports their efficacy for distressed couples, including evidence from trials contrasting IBCT with traditional behavioral couple therapy (Briggs et al., 2015; Christensen et al., 2004). In infertility samples, integrative behavioral couple therapy has been associated with improvements in infertility self-efficacy, dyadic adjustment, and sexual satisfaction, suggesting that integrative models are clinically appropriate for infertility-related relational strain even if ACT-C shows advantages on specific conflict-style endpoints in the current dataset (Vaziri Nia et al., 2021; Vazirnia et al., 2021). A plausible interpretation is that ACT-C more directly targeted avoidance-driven interpersonal repertoires (e.g., withdrawal) by increasing willingness to remain in difficult conversations and act in alignment with relational values, whereas integrative couple therapy may have exerted its effects through broader relational restructuring that improved overall functioning but did not differentially shift certain avoidance-embedded styles in comparison with ACT-C.

Finally, the absence of significant differences between ACT-C and integrative couple therapy in sexual satisfaction—despite improvement over time in both intervention groups relative to control—is clinically informative. Infertility commonly disrupts sexual desire, spontaneity, and erotic meaning by medicalizing sexual activity and amplifying performance concerns, and improvements in sexual satisfaction may require both reduced distress and restored relational safety and intimacy (Azar et al., 2024; Oehler et al., 2021). That both therapies improved sexual satisfaction suggests that enhancing couple communication, reducing conflict strain, and improving emotional acceptance can have downstream benefits for sexual well-being, consistent with broader evidence that psychological interventions can improve marital and sexual satisfaction in infertility contexts (Fredriksen & et al., 2015; Mokhtari Serkhani et al., 2021). ACT-focused work has shown promise for sexual outcomes such as sexual satisfaction, intimacy, sexual functioning, and sexual self-efficacy, supporting the idea that flexibility processes are relevant to sexual domains (Aghighi, 2023; Ahmadi, 2025; Behbahani & Ghorban Shiroudi, 2020). Integrative and IBCT-oriented approaches also have empirical grounding for enhancing dyadic adjustment and, in some studies, sexual satisfaction among infertile couples, suggesting multiple therapeutic routes can yield comparable gains in sexual satisfaction when relational distress is reduced (Vaziri Nia et al., 2021; Vazirnia et al., 2021). The lack of differential effects may therefore reflect a "common outcome" domain that responds to general improvements in relational functioning and emotional climate rather than to model-specific mechanisms, especially over the study's intervention duration. Additionally, sexual satisfaction is multi-determined and shaped by relationship stability, communication quality, and self-evaluative processes; longitudinal evidence supports that early relational and personal factors contribute meaningfully to sexual satisfaction trajectories (Hicks et al., 2021; Larson et al., 1998). It is also plausible that infertility-related sexual concerns may require targeted sex-therapy components or longer follow-up to detect between-model differences, particularly where medical treatment cycles continue to impose external constraints (Oehler et al., 2021; Selmasi et al., 2022). From a broader couple-therapy perspective, the present pattern is consistent with the field's view that multiple evidence-based couple therapy models yield meaningful improvements, while comparative advantages often emerge on specific mechanisms or subdomains rather than on broad relational outcomes (Pintea et al., 2019; Snyder et al., 2019; Snyder & Balderrama-durbin, 2022).

The stability of effects from posttest to follow-up across many indices further supports the clinical utility of both

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interventions in infertile couples, suggesting that changes in dysfunctional beliefs, avoidance processes, and conflict styles can persist beyond the immediate treatment window. This is consistent with conceptualizations of infertility as a chronic stressor requiring durable coping and relational skills, and with the argument that process-based interventions supporting flexible responding may have sustained benefits in contexts characterized by recurring uncertainty (Greil et al., 2010; Pasch & Sullivan, 2017). Given that alliance processes and rupture–repair dynamics can influence the durability of change—particularly in acceptance-based approaches—future implementation and training may benefit from explicit attention to alliance repair when infertility-related blame, withdrawal, or shame-based reactions arise in sessions (Walser & O'Connell, 2023).

5. Conclusion

Taken together, the findings imply that ACT-C may offer a more potent route for reducing experiential avoidance and specific dysfunctional beliefs and for shifting certain conflict-resolution styles, while integrative couple therapy remains a robust option that yields broadly comparable improvements in sexual satisfaction and meaningful gains across relational domains.

6. Limitations & Suggestions

The study had several limitations. The sample size was modest, and attrition reduced the analyzed sample in the intervention arms, which can limit statistical power and the stability of parameter estimates. The use of self-report measures may increase shared-method variance and may not capture behavioral interaction patterns as observed in vivo. The sample was drawn from a single infertility center, which may constrain generalizability to other regions, service settings, and infertility treatment contexts. Follow-up was relatively short, and longer-term maintenance across repeated medical treatment cycles remains uncertain.

Future research should replicate these findings with larger, multisite samples and with designs that increase representativeness across infertility diagnoses, treatment stages, and socio-cultural contexts. Studies should incorporate multimethod assessment (e.g., observational coding of couple interaction, clinician-rated indices, ecological momentary assessment) to clarify whether changes in beliefs and avoidance translate into measurable changes in real-time conflict behavior and intimacy. Mechanism-focused trials should test mediational pathways (e.g., whether reductions in experiential avoidance mediate improvements in conflict resolution and sexual satisfaction) and examine moderators such as infertility duration, stigma intensity, prior treatment failures, and baseline distress severity. Longer follow-up windows would clarify whether gains persist across subsequent treatment cycles and whether booster sessions improve maintenance.

For practice, the results support integrating structured couple-based psychological interventions into infertility services, with careful attention to both relational distress and sexual well-being. Clinicians may prioritize ACT-consistent strategies when couples present with pronounced avoidance, rigid belief systems about disagreement and partner changeability, or entrenched withdrawal/compliance patterns during conflict. Integrative couple therapy approaches remain appropriate when the clinical formulation emphasizes interactional cycles, emotional acceptance, and behavioral change within the relationship, particularly when couples seek broad relational improvement. Collaborative care models that coordinate mental health support with infertility medical care may be especially beneficial, and incorporating psychoeducation about infertility-related stress, communication skills, and intimacy support can enhance treatment relevance and engagement.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

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

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

S.H.A. was responsible for the conceptualization of the study, formulation of the research objectives, and overall supervision of the research process. M.S. contributed to the methodological design, provided scientific consultation on the therapeutic frameworks, and critically reviewed the study protocol and analyses. A.M.R. conducted participant recruitment and screening, coordinated and implemented the intervention sessions, performed the statistical analyses, and drafted the results section. All authors jointly contributed to the literature review, interpretation of findings, manuscript writing and revision, approved the final version of the manuscript, and take full responsibility for the integrity and accuracy of the work.

Declaration

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

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