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Comparing the Effectiveness of Cognitive Behavioral Therapy and Reality Therapy on Family Boundaries and Differentiation of Self

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A B S T R A C T

Objective: The present study aimed to compare the effectiveness of cognitive behavioral therapy and reality therapy on family boundaries and differentiation of self among married individuals in Tehran.

Methods and Materials: This quasi-experimental study was conducted using a pretest–posttest design with a control group and follow-up phase. The statistical population included married individuals living in Tehran who had referred to counseling and psychological service centers because of marital or family-related difficulties. A total of 45 eligible participants were selected through purposive sampling and randomly assigned to three equal groups: cognitive behavioral therapy, reality therapy, and control, with 15 participants in each group. The cognitive behavioral therapy and reality therapy groups each received eight weekly 90-minute group intervention sessions, while the control group remained on the waiting list and received no intervention during the study period. Data were collected using the Family Relational Boundaries Questionnaire and the Differentiation of Self Inventory-Revised. Data were analyzed using repeated-measures analysis of variance and Bonferroni post hoc tests.

Findings: The results showed that the main effect of time was significant for family boundaries, $F(2, 84) = 68.42$, $p < 0.001$, $\eta^2 = 0.620$, and differentiation of self, $F(2, 84) = 80.54$, $p < 0.001$, $\eta^2 = 0.657$. The group effect was also significant for family boundaries, $F(2, 42) = 17.96$, $p < 0.001$, $\eta^2 = 0.461$, and differentiation of self, $F(2, 42) = 18.74$, $p < 0.001$, $\eta^2 = 0.472$. The time × group interaction was significant for family boundaries, $F(4, 84) = 24.80$, $p < 0.001$, $\eta^2 = 0.542$, and differentiation of self, $F(4, 84) = 29.21$, $p < 0.001$, $\eta^2 = 0.582$. Bonferroni comparisons indicated that both interventions were significantly more effective than the control condition, and cognitive behavioral therapy was significantly more effective than reality therapy.

Conclusion: The findings indicated that both cognitive behavioral therapy and reality therapy improved family boundaries and differentiation of self, but cognitive behavioral therapy produced stronger and more stable effects.

Keywords: *Cognitive behavioral therapy; reality therapy; family boundaries; differentiation of self; family functioning; marital counseling.*

1. Introduction

Family functioning is one of the central contexts in which individuals develop emotional regulation, interpersonal identity, autonomy, intimacy, responsibility, and psychological resilience. The family is not merely a social unit composed of biologically or legally connected

members; rather, it is a dynamic relational system in which emotional closeness, role expectations, communication patterns, power distribution, and personal autonomy are continuously negotiated. From a systemic perspective, psychological symptoms and interpersonal difficulties are often embedded in recurrent family interaction patterns, particularly when the boundaries among family members are either excessively rigid or excessively diffuse. In families with rigid boundaries, emotional distance, limited support, poor communication, and reduced responsiveness may weaken members' sense of belonging. In contrast, families with diffuse or enmeshed boundaries may restrict individual autonomy, intensify emotional dependence, and reduce the capacity of members to develop a stable and differentiated self. Therefore, healthy family boundaries represent a balanced relational structure in which emotional connection and personal independence coexist. This balance is especially important in marital and family life because individuals must simultaneously preserve personal identity and participate in close emotional relationships. Contemporary family and psychotherapy literature emphasizes that intervention with family-related difficulties requires attention to interpersonal context, emotional patterns, developmental history, and the broader ecology of the person (Lebow et al., 2024; Satyanarayana et al., 2024; Tretter & Löffler-Stastka, 2021; Xue, 2023).

Family boundaries refer to the psychological, emotional, and behavioral limits that organize relationships among family members. These boundaries regulate who participates in family decisions, how emotional information is shared, how responsibilities are distributed, and how individuals maintain closeness without losing separateness. Functional boundaries are neither impermeable nor chaotic; they are sufficiently flexible to allow emotional support and sufficiently clear to protect individuality. When family boundaries are unclear, individuals may experience role confusion, excessive emotional involvement, dependency, guilt, triangulation, and difficulty making independent decisions. When boundaries are overly rigid, family members may experience isolation, emotional cutoff, and reduced intimacy. Such boundary disturbances may contribute to marital conflict, parent–child tension, emotional dysregulation, and reduced psychological adjustment. Recent clinical and family studies have highlighted that family problems are often maintained by dysfunctional communication patterns, unresolved conflict, trauma-related responses, and maladaptive relational expectations (Kress et al., 2024; Lee et al., 2023; Owens & Mascarenas, 2025; Samadi et al., 2023). Consequently, improving family boundaries is a major therapeutic goal in interventions that aim to enhance psychological health, marital adjustment, and relational functioning.

Differentiation of self is another fundamental construct in family systems theory and is closely related to the quality of family boundaries. Differentiation of self refers to the individual's ability to maintain a clear sense of personal identity while remaining emotionally connected to significant others. A differentiated person can think, decide, and act according to personal values while still participating in intimate relationships. Low differentiation is usually reflected in emotional reactivity, fusion with others, emotional cutoff, and difficulty maintaining an "I-position" under interpersonal pressure. Individuals with low differentiation may become overwhelmed by family conflict, excessively dependent on approval, unable to tolerate disagreement, or inclined to withdraw emotionally in order to avoid relational tension. In contrast, higher differentiation supports emotional regulation, responsible decision-making, self-directed behavior, and healthier relational participation. Differentiation of self is therefore not an individual trait isolated from the family context; it is shaped and expressed through repeated relational experiences within the family system. Studies on family systems, marital adjustment, and emotional functioning have repeatedly emphasized the importance of differentiation for psychological adaptation, intimacy, and relational stability (Besharat Qaramaleki et al., 2024; Hadian et al., 2023; Mazaheri Tehrani et al., 2022; Xue, 2023).

The relationship between family boundaries and differentiation of self is reciprocal. Clear boundaries provide the interpersonal conditions in which individuals can experience both belonging and autonomy, while higher differentiation enables individuals to respect boundaries without interpreting separateness as rejection or closeness as loss of self. In families characterized by enmeshment, differentiation is weakened because personal decisions become strongly regulated by the emotional climate of the family. In families characterized by disengagement, differentiation may also be compromised because emotional distance can be mistaken for autonomy, while in reality the person may lack the ability to remain connected during disagreement or stress. Thus, differentiation of self requires more than independence; it involves the capacity to remain emotionally present without becoming fused, reactive, or avoidant. This conceptual connection makes family boundaries and differentiation of self appropriate

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simultaneous outcomes for therapeutic interventions aimed at improving family functioning. Clinical writings on personality, anger, dissociation, psychosis, and complex emotional symptoms also suggest that psychological difficulties should be understood through the interaction of personal vulnerabilities, relational contexts, and maladaptive coping patterns rather than through isolated symptoms alone (Banerjee, 2025; Magnavita & Ingram, 2024; Manfredi & Taglietti, 2022; West et al., 2021; Zhu, 2023).

Cognitive behavioral therapy is one of the most widely studied psychological interventions and is based on the assumption that emotions and behaviors are influenced by cognitive interpretations, beliefs, and information-processing patterns. In the context of family boundaries and differentiation of self, cognitive behavioral therapy may be useful because many boundary problems are maintained by distorted beliefs about rejection, responsibility, guilt, obedience, control, approval, and emotional safety. For example, a person may believe that disagreement means disloyalty, that setting boundaries is selfish, that personal needs should always be sacrificed for the family, or that emotional distance is the only way to avoid conflict. These beliefs can intensify fusion, emotional reactivity, avoidance, or rigid relational patterns. Cognitive behavioral therapy helps individuals identify automatic thoughts, challenge dysfunctional assumptions, develop alternative interpretations, and practice adaptive behaviors such as assertive communication, emotion regulation, problem solving, and boundary setting. Evidence across clinical domains shows that cognitive behavioral approaches have been applied effectively in individual, family-based, medical, adolescent, trauma-related, and digital intervention contexts (Csirmaz et al., 2023; Guadagnoli et al., 2022; Hesapcioglu et al., 2026; Sookman et al., 2021; Zhang et al., 2025).

The relevance of cognitive behavioral therapy to the present study is also supported by its structured and skills-based nature. Because family boundary problems often appear in repeated patterns of interpretation and response, interventions that combine cognitive restructuring with behavioral rehearsal can help participants translate insight into practical interpersonal change. Cognitive behavioral therapy can target emotional reactivity by teaching individuals to identify triggering situations, evaluate cognitive distortions, and respond with deliberate rather than impulsive behaviors. It can strengthen the I-position by helping participants clarify personal values and communicate them assertively. It can reduce emotional cutoff by replacing avoidant coping with gradual and regulated communication. It can also reduce fusion by helping individuals distinguish between personal responsibility and excessive responsibility for others' emotions. Contemporary studies have extended cognitive behavioral principles to complex areas such as addiction-related behaviors, gaming disorder, internet addiction, obsessive–compulsive symptoms, and culturally or spiritually integrated treatment, showing the flexibility of CBT as a framework for modifying maladaptive cognition and behavior (Chadha et al., 2024; Özçelik & Toprak, 2025; Park et al., 2025; Tolin et al., 2025; Tsamalidou & Tragantzopoulou, 2025).

Reality therapy, derived from choice theory, represents another intervention approach that may be particularly relevant for family boundaries and differentiation of self. Reality therapy emphasizes personal choice, responsibility, self-evaluation, and effective behavior in the service of basic psychological needs, including love and belonging, power, freedom, fun, and survival. From this perspective, psychological distress and relational conflict often emerge when individuals attempt to meet their needs through ineffective, controlling, dependent, or avoidant behaviors. In family life, unclear boundaries and low differentiation may be understood as patterns in which individuals either surrender personal choice to maintain connection or attempt to control others in order to reduce insecurity. Reality therapy helps clients examine what they want, what they are doing, whether their current behavior is effective, and what realistic plan they can implement. The WDEP framework—wants, doing, evaluation, and planning—provides a practical structure through which individuals can assume responsibility for relational choices without blaming others or denying their own needs. This emphasis on responsibility, choice, and present behavior makes reality therapy conceptually suitable for improving family boundaries and differentiation of self (Besharat Qaramaleki et al., 2024; Bhuvaneswari & Kaur, 2024; Hadian et al., 2023; Samadi et al., 2023).

Reality therapy may affect family boundaries by encouraging individuals to evaluate whether their relational behaviors are helping them achieve healthy closeness and autonomy. A participant who habitually complies with family demands to avoid guilt may learn to recognize the difference between responsible care and self-neglect. A participant who uses withdrawal, criticism, or control may evaluate whether such behaviors truly meet the need for belonging or instead damage relationships. Through realistic

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planning, clients can develop specific behavioral commitments such as expressing needs directly, reducing blame, respecting others' choices, and making decisions based on internal responsibility rather than external pressure. Studies comparing reality therapy with other approaches and examining its effect on adjustment, self-efficacy, cognitive flexibility, self-differentiation, marital adjustment, intimacy, family communication, and emotional recovery indicate that reality therapy can be useful in relational and family-related outcomes (Besharat Qaramaleki et al., 2024; Bhuvaneswari & Kaur, 2024; Mazaheri Tehrani et al., 2022; Samadi et al., 2023; Zarean et al., 2023).

Despite their differences, cognitive behavioral therapy and reality therapy share several therapeutic features that justify their comparison. Both approaches are relatively structured, present-oriented, goal-focused, and concerned with helping clients modify ineffective patterns. However, their mechanisms of change are different. Cognitive behavioral therapy primarily emphasizes the identification and modification of dysfunctional thoughts and beliefs that influence emotional and behavioral responses. Reality therapy, in contrast, emphasizes personal choice, responsibility, need satisfaction, and evaluation of current behavior. Therefore, CBT may be expected to produce change by altering the cognitive schemas that maintain unhealthy boundaries and low differentiation, whereas reality therapy may produce change by strengthening responsibility, self-evaluation, and intentional behavioral planning. The comparative examination of these two approaches is important because family boundaries and differentiation of self include both cognitive-emotional and choice-behavioral components. Contemporary psychotherapy literature increasingly emphasizes that different models should be compared not only in terms of symptom reduction but also in terms of their capacity to influence relational functioning, self-regulation, and adaptive behavior (Castonguay et al., 2023; DeGrush & LaFrance, 2022; Ottingerová et al., 2026; Tolin et al., 2025).

The need for such comparison becomes more important when considering the diversity and complexity of psychological interventions. Recent literature has shown that psychotherapy is increasingly moving toward integrative, competency-based, culturally sensitive, and contextually informed models. Interventions are no longer evaluated only by their theoretical elegance, but also by their practical applicability, therapist competence, client characteristics, cultural fit, and sustainability of effects. Cognitive, phenomenological, psychodynamic, experiential, spiritual, and emerging treatment approaches have all contributed to contemporary discussions about how psychological change occurs and how interventions should be tailored to complex human problems (Castellini et al., 2022; Castonguay et al., 2023; Foe, 2023; Fung et al., 2023; Ottingerová et al., 2026). In this context, comparing CBT and reality therapy can provide useful evidence for clinicians working with family and marital problems, particularly when the treatment goals are not limited to symptom reduction but include strengthening relational boundaries, autonomy, emotional balance, and self-directed functioning.

Family and marital difficulties are often influenced by developmental stressors, sociocultural expectations, digital stress, emotional trauma, and changing communication patterns. For example, contemporary families may experience pressure from social media, online communication, intergenerational expectations, economic stress, and shifting gender or marital roles, all of which can affect boundaries and self-differentiation. Clinical literature on adolescents, emerging adults, trauma, self-injury, depression, eating-related problems, and family conflict indicates that relational context and emotional regulation are deeply connected to mental health outcomes (Apicella et al., 2025; Fang et al., 2025; Horovitz & Argyrides, 2023; Owens & Mascarenas, 2025; Satyanarayana et al., 2024). Although the present study focuses on married individuals rather than adolescents or clinical psychiatric populations, these bodies of literature support the broader argument that effective psychotherapy must address how individuals regulate emotion, interpret relational experiences, and participate in close relationships.

In addition, some psychological and behavioral problems require interventions that are sensitive to the person's wider social and ecological context. Rehabilitation, offender treatment, trauma-informed family therapy, and clinical work with complex behavioral patterns all indicate that sustainable change requires more than advice or insight; it requires structured therapeutic processes that support responsibility, emotional regulation, relational repair, and adaptive behavior in real-life contexts (Kress et al., 2024; Lee et al., 2023; Sakdalan & Mitchell, 2023; Волкова, 2021). This principle is directly relevant to family boundaries and differentiation of self because these constructs are expressed in everyday family interactions, not merely in internal attitudes. A person may understand the importance of boundaries but still be unable to implement them under emotional pressure. Similarly, a person may value autonomy but become fused, reactive, or avoidant

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during family conflict. Therefore, interventions must help participants transform insight into sustained relational behavior.

Although previous studies have separately supported the effectiveness of cognitive behavioral therapy and reality therapy for various psychological, marital, and family-related outcomes, fewer studies have directly compared these two approaches in relation to family boundaries and differentiation of self. Existing Iranian and international research suggests that reality therapy can improve marital adjustment, intimacy, emotional differentiation, self-differentiation, cognitive flexibility, family communication patterns, responsibility, and self-efficacy (Besharat Qaramaleki et al., 2024; Hadian et al., 2023; Mazaheri Tehrani et al., 2022; Samadi et al., 2023; Zarean et al., 2023). Meanwhile, the broader CBT literature has demonstrated strong applicability across individual, family-based, child, adolescent, trauma-related, and behavioral domains (Csirmaz et al., 2023; Guadagnoli et al., 2022; Hesapcioglu et al., 2026; Sookman et al., 2021; Zhang et al., 2025). However, because CBT and reality therapy emphasize different pathways of change, direct comparison can clarify whether cognitive restructuring and behavioral skill training or responsibility-based choice and self-evaluation are more effective for improving boundary functioning and differentiation.

Accordingly, the present study was conducted to compare the effectiveness of cognitive behavioral therapy and reality therapy on family boundaries and differentiation of self among married individuals in Tehran.

2. Methods and Materials

2.1. Study Design and Participants

The present study was conducted using a quasi-experimental pretest–posttest design with a control group and a follow-up phase in order to compare the effectiveness of cognitive behavioral therapy and reality therapy on family boundaries and differentiation of self. The statistical population consisted of married individuals living in Tehran who had referred to counseling and psychological service centers because of interpersonal, marital, or family-related difficulties. From this population, 45 eligible participants were selected through purposive sampling based on the inclusion and exclusion criteria and were then randomly assigned to three equal groups: the cognitive behavioral therapy group, the reality therapy group, and the control group, with 15 participants in each group. The inclusion criteria were being married, residing in Tehran, willingness to participate in the study, ability to attend all treatment sessions, absence of simultaneous participation in another psychological intervention, and obtaining scores indicating difficulties in family boundaries or differentiation of self at the initial screening stage. The exclusion criteria included absence from more than two treatment sessions, severe psychiatric disorder requiring immediate specialized intervention, use of intensive concurrent psychotherapy during the study period, and unwillingness to continue participation. Before the beginning of the intervention, all participants were informed about the objectives of the study, the voluntary nature of participation, confidentiality of information, and their right to withdraw from the study at any stage without any negative consequence. After obtaining informed consent, the pretest was administered to all three groups. The two experimental groups then received their respective interventions, whereas the control group did not receive any psychological intervention during the same period and remained on the waiting list. Immediately after the completion of the intervention sessions, the posttest was administered to all participants, and the follow-up assessment was conducted after the specified interval to examine the stability of the intervention effects.

2.2. Measures

The demographic information form was used to collect background information about the participants. This form was prepared by the researchers and included questions regarding age, gender, duration of marriage, educational level, employment status, number of children, and history of receiving psychological or counseling services. The purpose of using this form was to describe the sample characteristics and to ensure that the three groups were generally comparable in terms of important demographic variables before the implementation of the interventions. The information obtained from this form was used only for research purposes and was analyzed in aggregate form.

The Family Relational Boundaries Questionnaire was used to assess the quality of boundaries in family relationships. This instrument evaluates the extent to which family members experience clear, flexible, healthy, rigid, diffuse, or problematic relational boundaries in the family system. The questionnaire is based on systemic and structural views of family functioning, in which boundaries are considered essential for regulating closeness, autonomy, hierarchy, emotional exchange, and interpersonal roles

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within the family. Higher scores on adaptive dimensions indicate healthier and more functional boundaries, whereas higher scores on maladaptive dimensions reflect difficulties such as enmeshment, rigidity, role confusion, excessive emotional involvement, or inappropriate distancing among family members. In the present study, this questionnaire was used to determine participants' level of family boundary functioning before and after the interventions (Burmykina, 2024; Kamboj, 2024; Rezapour Chours et al., 2025; Wood, 2017). The validity and reliability of the instrument have been supported in previous psychometric studies, and in the present study, internal consistency was also examined using Cronbach's alpha coefficient.

The Differentiation of Self Inventory-Revised was used to measure differentiation of self. This scale assesses the individual's ability to maintain emotional balance, preserve a clear sense of self, and remain connected to significant others without losing autonomy or becoming emotionally fused. The revised form includes the main dimensions of emotional reactivity, I-position, emotional cutoff, and fusion with others. Emotional reactivity refers to the tendency to respond to interpersonal stress with intense emotional arousal; I-position reflects the ability to maintain personal beliefs, values, and decisions under relational pressure; emotional cutoff refers to emotional distancing or withdrawal from significant relationships; and fusion with others reflects excessive emotional dependence and difficulty maintaining psychological separateness. Higher total scores indicate a more favorable level of differentiation of self. This instrument was selected because it is theoretically consistent with family systems theory and is widely used in studies related to marital and family functioning (Parsakia et al., 2023; Xu et al., 2025). Previous studies have confirmed the validity and reliability of this instrument, and in the present study, Cronbach's alpha coefficient was calculated to assess its internal consistency in the sample.

2.3. Interventions

The cognitive behavioral therapy intervention was implemented in a structured group format for the participants assigned to the cognitive behavioral therapy group. The protocol consisted of eight weekly sessions, each lasting approximately 90 minutes. The intervention was designed to help participants identify dysfunctional thoughts, emotional reactions, and behavioral patterns that contributed to unhealthy family boundaries and low differentiation of self. In the initial sessions, participants were introduced to the cognitive behavioral model and the relationship between thoughts, emotions, behaviors, and interpersonal responses within the family context. Subsequent sessions focused on identifying automatic thoughts related to dependence, rejection, guilt, conflict, control, and emotional overinvolvement in family relationships. Cognitive restructuring techniques were used to challenge irrational beliefs and replace them with more balanced and adaptive interpretations. Behavioral exercises were also used to strengthen assertive communication, boundary-setting skills, emotional regulation, problem-solving, and self-directed decision-making. Participants were encouraged to practice between-session assignments, including thought records, behavioral experiments, assertive communication exercises, and monitoring of family interaction patterns. The final sessions emphasized relapse prevention, consolidation of learned skills, and development of individualized plans for maintaining healthy family boundaries and greater differentiation in everyday family interactions.

The reality therapy intervention was also implemented in a structured group format for the participants assigned to the reality therapy group. This protocol consisted of eight weekly sessions, each lasting approximately 90 minutes, and was developed based on the principles of choice theory and reality therapy. The main therapeutic focus was on helping participants recognize their personal responsibility, clarify their needs, evaluate their current behaviors, and make more effective choices in family relationships. In the early sessions, participants became familiar with the basic concepts of reality therapy, including basic psychological needs, quality world, total behavior, personal choice, and responsibility. The sessions then focused on helping participants examine how their current behaviors affected their family boundaries, emotional dependence, autonomy, and relational functioning. The WDEP framework was used throughout the intervention, including exploration of wants, current doing, self-evaluation, and planning. Participants were guided to distinguish between controllable and uncontrollable aspects of family relationships and to replace blaming, withdrawal, fusion, or controlling behaviors with responsible and need-satisfying alternatives. Practical exercises were used to strengthen decision-making, commitment, self-evaluation, respectful communication, and realistic planning for healthier family interactions. In the final sessions, participants reviewed their progress, identified obstacles to maintaining change, and developed concrete plans for continuing responsible choices, balanced

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emotional closeness, and functional boundaries in family life.

2.4. Data Analysis

The collected data were analyzed using descriptive and inferential statistical methods. At the descriptive level, mean, standard deviation, frequency, and percentage were used to report demographic characteristics and the scores of family boundaries and differentiation of self in the pretest, posttest, and follow-up stages. Before conducting inferential analyses, the assumptions of parametric testing were examined. The normality of score distributions was assessed using the Shapiro–Wilk test, and the homogeneity of variances was examined using Levene's test. In addition, the homogeneity of regression slopes and other assumptions related to covariance analysis were evaluated before the main comparisons. To compare the effectiveness of cognitive behavioral therapy and reality therapy with the control condition, analysis of covariance was used by controlling the pretest scores. When significant differences were observed among the groups, Bonferroni post hoc comparisons were conducted to determine the exact location of the differences between the cognitive behavioral therapy, reality therapy, and control groups. The level of statistical significance was set at 0.05. All analyses were performed using SPSS software, and effect size indices were reported in order to determine the practical magnitude of the intervention effects.

3. Findings and Results

The present study included 45 married participants from Tehran who were assigned to three equal groups: cognitive behavioral therapy, reality therapy, and control, with 15 participants in each group. The total sample consisted of 29 women and 16 men. The mean age of the participants was 34.87 years with a standard deviation of 6.21. The mean duration of marriage was 8.62 years with a standard deviation of 4.73. In terms of educational level, 6 participants had a high school diploma, 25 participants had an associate or bachelor's degree, and 14 participants had a master's degree or higher. Regarding employment status, 24 participants were employed, 14 were homemakers, and 7 were self-employed. With respect to the number of children, 12 participants had no children, 15 had one child, and 18 had two or more children. The comparison of demographic characteristics among the three groups showed no statistically significant differences in age, duration of marriage, gender distribution, educational level, employment status, or number of children. The results of one-way analysis of variance showed that the three groups were homogeneous in terms of age, $F(2, 42) = 0.04$, $p = 0.964$, and duration of marriage, $F(2, 42) = 0.09$, $p = 0.914$. In addition, the results of chi-square tests indicated no significant differences among the groups in gender, educational level, employment status, or number of children, $p > 0.05$. Therefore, the three groups were comparable in terms of the main demographic characteristics before the implementation of the interventions.

Before conducting the main inferential analyses, the assumptions of parametric testing were examined. The results of the Shapiro–Wilk test indicated that the distributions of family boundaries and differentiation of self scores were normal in the three groups across the pretest, posttest, and follow-up stages, $p > 0.05$. Levene's test also confirmed the homogeneity of variances for the dependent variables at the assessment stages, $p > 0.05$. In addition, Mauchly's test of sphericity was not statistically significant for family boundaries or differentiation of self, indicating that the assumption of sphericity was met. Therefore, repeated-measures analysis of variance and Bonferroni post hoc comparisons were used to examine the effectiveness of the interventions and to compare the cognitive behavioral therapy, reality therapy, and control groups.

Table 1

Descriptive Statistics of Family Boundaries and Differentiation of Self in the Three Groups Across Pretest, Posttest, and Follow-up

Variable	Group	N	Pretest Mean	Pretest SD	Posttest Mean	Posttest SD	Follow-up Mean	Follow-up SD
Family boundaries	Cognitive behavioral therapy	15	67.80	8.24	88.93	7.18	87.60	7.35
Family boundaries	Reality therapy	15	68.47	7.91	83.40	7.02	82.27	7.38

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Family boundaries	Control	15	69.13	8.05	70.20	8.11	69.73	8.36
Differentiation of self	Cognitive behavioral therapy	15	133.60	14.72	164.87	13.65	162.73	14.10
Differentiation of self	Reality therapy	15	134.73	15.08	154.60	13.91	152.87	14.24
Differentiation of self	Control	15	135.20	14.55	136.47	15.02	135.93	14.88

As shown in Table 1, the pretest mean scores of family boundaries and differentiation of self were relatively similar across the three groups, indicating that the groups were comparable before the interventions. In the posttest stage, both intervention groups showed improvement compared with the control group; however, the increase was more pronounced in the cognitive behavioral therapy group. The mean score of family boundaries in the cognitive behavioral therapy group increased from 67.80 at pretest to 88.93 at posttest and remained relatively stable at 87.60 during follow-up. In the reality therapy group, the mean score of family boundaries increased from 68.47 at pretest to 83.40 at posttest and remained at 82.27 during follow-up. In contrast, the control group showed only a minimal change, increasing from 69.13 at pretest to 70.20 at posttest and decreasing slightly to 69.73 at follow-up. A similar pattern was observed for differentiation of self. The cognitive behavioral therapy group showed an increase from 133.60 at pretest to 164.87 at posttest, with a follow-up mean of 162.73. The reality therapy group increased from 134.73 at pretest to 154.60 at posttest, with a follow-up mean of 152.87. The control group showed no meaningful change, with scores of 135.20 at pretest, 136.47 at posttest, and 135.93 at follow-up. These descriptive findings suggest that both cognitive behavioral therapy and reality therapy were associated with improved family boundaries and differentiation of self, while cognitive behavioral therapy produced stronger changes than reality therapy.

Table 2

Results of Repeated-Measures Analysis of Variance for Family Boundaries and Differentiation of Self

Variable	Source of Effect	Sum of Squares	df	Mean Square	F	p	Partial Eta Squared
Family boundaries	Time	5145.29	2	2572.65	68.42	<0.001	0.620
Family boundaries	Group	3581.74	2	1790.87	17.96	<0.001	0.461
Family boundaries	Time × Group	3729.58	4	932.39	24.80	<0.001	0.542
Family boundaries	Error for time	3157.82	84	37.59	—	—	—
Family boundaries	Error for group	4187.31	42	99.70	—	—	—
Differentiation of self	Time	11342.44	2	5671.22	80.54	<0.001	0.657
Differentiation of self	Group	9875.63	2	4937.82	18.74	<0.001	0.472
Differentiation of self	Time × Group	8229.71	4	2057.43	29.21	<0.001	0.582
Differentiation of self	Error for time	5916.88	84	70.44	—	—	—
Differentiation of self	Error for group	11064.79	42	263.45	—	—	—

According to Table 2, the results of repeated-measures analysis of variance showed that the main effect of time was statistically significant for family boundaries, $F(2, 84) = 68.42$, $p < 0.001$, $\eta^2 = 0.620$, indicating that the scores of family boundaries changed significantly from pretest to posttest and follow-up. The main effect of group was also significant, $F(2, 42) = 17.96$, $p < 0.001$, $\eta^2 = 0.461$, showing that there were significant differences among the cognitive behavioral therapy, reality therapy, and control groups. More importantly, the interaction effect of time and group was statistically significant, $F(4, 84) = 24.80$, $p < 0.001$, $\eta^2 = 0.542$. This interaction indicates that the pattern of change in family boundaries over time was different across the three groups and that the observed improvement was related to the interventions rather than to the passage of time alone. For differentiation of self, the main effect of time was significant, $F(2, 84) = 80.54$, $p < 0.001$, $\eta^2 = 0.657$, and the main effect of group was also significant, $F(2, 42) = 18.74$, $p < 0.001$, $\eta^2 = 0.472$. The time × group interaction was significant as well, $F(4, 84) = 29.21$, $p < 0.001$, $\eta^2 = 0.582$. These findings indicate that differentiation of self improved significantly over time in the intervention groups, while the control group showed no meaningful change. The partial eta squared values demonstrated large effect sizes, suggesting that both interventions had substantial effects on the dependent variables, with stronger effects observed for differentiation of self.

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Table 3

Bonferroni Post Hoc Comparisons of Group Differences at Posttest and Follow-up

Variable	Assessment Stage	Group Comparison	Mean Difference	Standard Error	p	95% Confidence Interval
Family boundaries	Posttest	Cognitive behavioral therapy – Reality therapy	5.53	2.64	0.043	0.12 to 10.94
Family boundaries	Posttest	Cognitive behavioral therapy – Control	18.73	2.64	<0.001	13.32 to 24.14
Family boundaries	Posttest	Reality therapy – Control	13.20	2.64	<0.001	7.79 to 18.61
Family boundaries	Follow-up	Cognitive behavioral therapy – Reality therapy	5.33	2.58	0.048	0.03 to 10.63
Family boundaries	Follow-up	Cognitive behavioral therapy – Control	17.87	2.58	<0.001	12.57 to 23.17
Family boundaries	Follow-up	Reality therapy – Control	12.54	2.58	<0.001	7.24 to 17.84
Differentiation of self	Posttest	Cognitive behavioral therapy – Reality therapy	10.27	5.11	0.049	0.05 to 20.49
Differentiation of self	Posttest	Cognitive behavioral therapy – Control	28.40	5.11	<0.001	18.18 to 38.62
Differentiation of self	Posttest	Reality therapy – Control	18.13	5.11	0.001	7.91 to 28.35
Differentiation of self	Follow-up	Cognitive behavioral therapy – Reality therapy	9.86	4.87	0.046	0.12 to 19.60
Differentiation of self	Follow-up	Cognitive behavioral therapy – Control	26.80	4.87	<0.001	17.06 to 36.54
Differentiation of self	Follow-up	Reality therapy – Control	16.94	4.87	0.002	7.20 to 26.68

As shown in Table 3, the Bonferroni post hoc comparisons indicated that both cognitive behavioral therapy and reality therapy were significantly more effective than the control condition in improving family boundaries and differentiation of self at both posttest and follow-up. For family boundaries, the cognitive behavioral therapy group had significantly higher posttest scores than the reality therapy group, with a mean difference of 5.53, $p = 0.043$, and significantly higher scores than the control group, with a mean difference of 18.73, $p < 0.001$. The reality therapy group also had significantly higher family boundary scores than the control group at posttest, with a mean difference of 13.20, $p < 0.001$. These differences remained significant at follow-up, indicating that the effects of both interventions were maintained over time. The same pattern was observed for differentiation of self. At posttest, the cognitive behavioral therapy group had significantly higher differentiation of self scores than the reality therapy group, with a mean difference of 10.27, $p = 0.049$, and significantly higher scores than the control group, with a mean difference of 28.40, $p < 0.001$. The reality therapy group also scored significantly higher than the control group, with a mean difference of 18.13, $p = 0.001$. At follow-up, the cognitive behavioral therapy group continued to show significantly higher differentiation of self scores than both the reality therapy and control groups, and the reality therapy group also maintained significantly higher scores than the control group. Overall, the post hoc findings confirmed that both interventions were effective, but cognitive behavioral therapy had a stronger effect than reality therapy on both family boundaries and differentiation of self.

Overall, the findings of the study demonstrated that cognitive behavioral therapy and reality therapy significantly improved family boundaries and differentiation of self among married individuals in Tehran. The control group showed no meaningful improvement across the assessment stages, whereas both experimental groups showed clear increases from pretest to posttest, and these improvements were largely maintained during follow-up. The comparison between the two intervention approaches showed that cognitive behavioral therapy produced greater improvement than reality therapy in both dependent variables. Therefore, the results support the effectiveness of cognitive behavioral therapy and reality therapy for improving family functioning, while indicating the relative superiority of cognitive behavioral therapy in enhancing healthy family boundaries and differentiation of self.

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4. Discussion

The present study was conducted to compare the effectiveness of cognitive behavioral therapy and reality therapy on family boundaries and differentiation of self among married individuals in Tehran. The findings showed that both cognitive behavioral therapy and reality therapy significantly improved family boundaries and differentiation of self from pretest to posttest, and these improvements were largely maintained at follow-up. The control group did not show meaningful improvement across the assessment stages, which indicates that the observed changes in the experimental groups were not merely the result of time, repeated measurement, or spontaneous improvement. In addition, the results of between-group comparisons showed that cognitive behavioral therapy produced greater improvement than reality therapy in both family boundaries and differentiation of self. Therefore, the findings support the effectiveness of both therapeutic approaches, while also indicating the relative superiority of cognitive behavioral therapy for the outcomes examined in this study.

The first major finding of the study was that cognitive behavioral therapy significantly improved family boundaries. This result can be explained by the cognitive and behavioral mechanisms targeted in the CBT protocol. Many difficulties in family boundaries are maintained by dysfunctional beliefs such as "setting limits means rejection," "I am responsible for others' emotions," "disagreement destroys relationships," or "a good family member must always sacrifice personal needs." Such beliefs may lead to emotional fusion, excessive compliance, guilt, conflict avoidance, or rigid distancing. Cognitive behavioral therapy helps individuals identify these automatic thoughts, examine their validity, replace them with more adaptive interpretations, and practice new interpersonal behaviors. This process can strengthen clear communication, assertiveness, emotional regulation, and flexible boundary setting. The present finding is consistent with the broader evidence showing that CBT is an effective and structured approach for modifying maladaptive cognition and behavior across different psychological and relational problems (Guadagnoli et al., 2022; Sookman et al., 2021; Tolin et al., 2025). It is also compatible with studies emphasizing that family-based and relational applications of CBT can produce meaningful improvements by addressing interactional patterns, emotion regulation, and maladaptive beliefs within the family context (Satyanarayana et al., 2024; Zhang et al., 2025).

The effectiveness of CBT on family boundaries can also be interpreted in light of the central role of cognitive appraisal in family interactions. In many family relationships, boundary violations are not only behavioral events but also interpreted through emotional meanings. For example, a request for personal space may be interpreted as abandonment, and a disagreement may be experienced as disloyalty. When such interpretations dominate the family system, members may respond with anxiety, control, withdrawal, or dependency. CBT directly targets this interpretive process and enables participants to distinguish between facts, assumptions, emotions, and behavioral choices. This mechanism may explain why participants in the CBT group achieved stronger improvement in family boundary functioning. The finding is in line with clinical literature suggesting that psychotherapy is most effective when it helps clients identify patterns that maintain distress and translate insight into practical behavioral change (Castonguay et al., 2023; DeGrush & LaFrance, 2022). In addition, studies on clinical interventions for adolescents and families have shown that structured psychological treatments can improve emotional and interpersonal functioning when they combine psychoeducation, skill training, self-monitoring, and behavioral rehearsal (Csirmaz et al., 2023; Fang et al., 2025; Hesapcioglu et al., 2026).

The second major finding was that cognitive behavioral therapy significantly improved differentiation of self. Differentiation of self requires the ability to preserve personal identity and emotional balance while remaining connected to significant others. The CBT intervention may have strengthened this capacity by reducing emotional reactivity and increasing reflective decision-making. Participants learned to identify cognitive distortions, evaluate emotionally charged thoughts, and respond to family situations in a more deliberate manner. These skills are closely related to differentiation because a differentiated person does not automatically react to interpersonal pressure but can pause, think, and act according to values and realistic judgments. CBT may also strengthen the "I-position" by helping individuals clarify personal beliefs and communicate them without aggression or withdrawal. This result is aligned with the literature indicating that CBT can improve self-regulation, emotional control, and adaptive coping in various clinical populations (Chadha et al., 2024; Park et al., 2025; Sookman et al., 2021). It also corresponds with family systems perspectives that consider differentiation to be a key factor in emotional adjustment and family functioning (Lebow et al., 2024; Xue, 2023).

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The significant effect of reality therapy on family boundaries was another important finding of the present study. Reality therapy emphasizes choice, responsibility, need satisfaction, self-evaluation, and planning. Within family relationships, boundary problems often occur when individuals either attempt to control others or surrender their own needs in order to preserve connection. Reality therapy helps clients evaluate whether their current behaviors are helping them meet their needs effectively. Through the WDEP framework, participants examine what they want, what they are doing, whether their behavior is useful, and what realistic plan they can implement. This process may improve family boundaries by reducing blaming, emotional dependence, avoidance, and controlling behaviors. The result is consistent with studies showing that reality therapy can improve marital adjustment, intimacy, emotional differentiation, family communication patterns, responsibility, and self-efficacy (Besharat Qaramaleki et al., 2024; Hadian et al., 2023; Samadi et al., 2023). It is also supported by findings indicating that reality therapy can be useful in family conflict and emotional recovery because it encourages clients to take responsibility for their choices rather than remain trapped in ineffective relational patterns (Bhuvaneswari & Kaur, 2024).

The effect of reality therapy on differentiation of self can be explained by its focus on personal agency. Individuals with low differentiation often feel controlled by the emotional climate of the family, by others' approval, or by fear of conflict. Reality therapy helps individuals recognize that while they cannot control others, they can choose their own behaviors, evaluate the consequences of those behaviors, and make responsible plans. This orientation can strengthen autonomy and reduce emotional fusion. In addition, reality therapy encourages individuals to distinguish between external control and internal control, which is conceptually related to differentiation of self. When participants learn that they are responsible for their own behavior rather than for the emotional reactions of all family members, they may become more capable of maintaining a clear self while remaining relationally engaged. The present finding is consistent with research showing that reality therapy can improve self-differentiation and cognitive flexibility in mothers of children with special learning disorders (Mazaheri Tehrani et al., 2022). It also supports comparative research indicating that reality therapy can improve psychological adjustment and responsibility-related outcomes in women experiencing major relational and life stressors (Hadian et al., 2023; Zarean et al., 2023).

Another important result of the present study was that cognitive behavioral therapy was more effective than reality therapy in improving both family boundaries and differentiation of self. This relative superiority may be explained by the fact that CBT directly targets cognitive distortions, emotional reactivity, and behavioral patterns, all of which are central to both dependent variables. Family boundaries and differentiation of self are not only matters of choice or responsibility; they are also influenced by deeply held schemas about attachment, rejection, guilt, loyalty, conflict, and self-worth. CBT may have produced stronger effects because it provided participants with specific tools for identifying and restructuring these underlying beliefs. Reality therapy helped participants evaluate behavior and make responsible plans, but CBT may have more directly modified the cognitive-emotional processes that maintain unhealthy boundaries and low differentiation. This interpretation is consistent with the broad evidence base supporting CBT as a specialized and empirically supported treatment approach across a wide range of clinical conditions (Sookman et al., 2021; Tolin et al., 2025; Zhang et al., 2025). It also aligns with studies emphasizing the importance of therapist competence, structured intervention, and mechanism-focused treatment in achieving effective psychotherapy outcomes (Castonguay et al., 2023; Tsamalidou & Tragantzopoulou, 2025).

The greater impact of CBT may also be related to its emphasis on skill acquisition and repeated practice. In the present intervention, participants practiced thought records, cognitive restructuring, assertive communication, problem-solving, and behavioral experiments. Such techniques may be especially useful for individuals whose boundary problems are maintained by automatic emotional responses. For example, participants may understand that boundaries are important, but in real family situations they may quickly become anxious, guilty, angry, or avoidant. CBT provides practical methods for managing these reactions and replacing them with more adaptive responses. This may explain why the CBT group showed stronger posttest and follow-up scores than the reality therapy group. Previous research has shown that CBT-based interventions can be effective when they are structured, skills-oriented, and adapted to the client's clinical and developmental needs (Csirmaz et al., 2023; Guadagnoli et al., 2022; Hesapcioglu et al., 2026). In addition, contemporary psychotherapy literature has emphasized that effective treatment requires not only insight but also the acquisition of competencies that

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clients can apply outside the therapy session (Castonguay et al., 2023).

The maintenance of intervention effects at follow-up is also noteworthy. The findings showed that the gains achieved in both experimental groups were generally preserved after the completion of treatment. This suggests that the participants were able to use the learned skills beyond the immediate therapeutic context. In the CBT group, maintenance may have been supported by cognitive restructuring skills, self-monitoring, and behavioral assignments. In the reality therapy group, maintenance may have been supported by planning, self-evaluation, and responsibility-based decision-making. These findings are consistent with studies indicating that psychotherapy can produce sustained effects when clients learn practical strategies for managing real-life difficulties and when interventions target mechanisms that are relevant to everyday functioning (Ottingerová et al., 2026; Tolin et al., 2025). They are also compatible with Iranian studies showing continuity of reality therapy effects on marital and emotional outcomes (Besharat Qaramaleki et al., 2024; Mazaheri Tehrani et al., 2022).

The findings of this study also have broader implications for understanding family functioning. Family boundaries and differentiation of self are influenced by personal, relational, and contextual factors. Psychological problems cannot be understood only as internal symptoms; they are often embedded in interactional patterns and environmental pressures. This view is consistent with ecological and systemic perspectives that emphasize the interaction between the person and the environment (Tretter & Löffler-Stastka, 2021). It is also aligned with trauma-informed and culturally attuned family therapy approaches, which highlight the importance of relational history, family communication, and sociocultural context in psychological adjustment (Fung et al., 2023; Lee et al., 2023). Therefore, the effectiveness of CBT and reality therapy in this study may reflect their ability to help participants reorganize both internal responses and interpersonal behaviors within the family system.

The results can also be interpreted in relation to the increasing complexity of family life in contemporary societies. Digital communication, social media exposure, changing marital expectations, and intergenerational pressures may all influence the way family members define closeness, privacy, responsibility, and autonomy. Studies on digital distress, internet addiction, gaming disorder, and shared psychological phenomena in the digital age suggest that modern relational problems often emerge through new forms of connection, comparison, dependency, and emotional pressure (Banerjee, 2025; Chadha et al., 2024; Owens & Mascarenas, 2025; Park et al., 2025). Although the present study did not directly examine digital factors, the improvement of family boundaries and differentiation of self may help individuals respond more adaptively to these contemporary pressures by strengthening self-regulation, personal responsibility, and clear relational limits.

5. Conclusion

The findings show the importance of selecting interventions according to the nature of the therapeutic target. Some psychological problems require interventions that primarily reduce symptoms, while others require interventions that reorganize relational patterns, identity boundaries, and emotional responses. Literature on eating disorders, anger, dissociation, personality problems, psychosis, self-injury, and complex clinical presentations emphasizes that diagnosis, case formulation, and mechanism-based intervention are essential before selecting treatment methods (Apicella et al., 2025; Castellini et al., 2022; Manfredi & Taglietti, 2022; West et al., 2021; Zhu, 2023). In the present study, CBT may have shown stronger effects because it matched the cognitive-emotional structure of the target variables, while reality therapy remained effective because it addressed responsibility and behavioral choice. Thus, the results suggest that both approaches can be clinically valuable, but CBT may be preferable when the main therapeutic goals include restructuring dysfunctional beliefs, reducing emotional reactivity, and strengthening differentiated self-expression.

6. Limitations & Suggestions

This study had several limitations that should be considered when interpreting the findings. The sample was limited to married individuals in Tehran, and the participants were selected through purposive sampling; therefore, the generalizability of the results to other cities, rural populations, unmarried individuals, or families with different cultural and socioeconomic backgrounds should be made cautiously. The sample size was also relatively small, with 15 participants in each group, which may limit the statistical power of the study and reduce the ability to detect more subtle differences between interventions. Another limitation was reliance on self-report questionnaires, which may be influenced by social desirability, response bias, or

participants' subjective interpretation of items. In addition, the follow-up period was limited, and it is not possible to determine whether the intervention effects would remain stable over longer periods. Finally, the study examined family boundaries and differentiation of self as outcome variables but did not assess possible mediating mechanisms such as cognitive distortions, emotional regulation, responsibility, marital conflict, or communication patterns.

Future studies are recommended to replicate this research with larger samples and in different cultural, geographical, and clinical populations in order to increase the generalizability of the findings. It is also suggested that future research use randomized controlled trial designs with longer follow-up periods to evaluate the stability of therapeutic effects over time. Researchers may also examine mediating and moderating variables, such as emotional regulation, attachment style, marital satisfaction, communication patterns, psychological flexibility, responsibility, and cognitive distortions, to clarify how and for whom these interventions are most effective. Future studies could compare cognitive behavioral therapy and reality therapy with other family-oriented approaches, such as emotion-focused therapy, schema therapy, acceptance and commitment therapy, or systemic family therapy. In addition, the use of mixed-method designs may provide deeper insight into participants' lived experiences of boundary change and self-differentiation during the therapeutic process.

Based on the findings, counselors and family therapists can use both cognitive behavioral therapy and reality therapy to improve family boundaries and differentiation of self among married individuals. Cognitive behavioral therapy may be especially useful when clients experience intense emotional reactivity, guilt, irrational beliefs about family roles, fear of rejection, or difficulty expressing personal needs. Reality therapy may be particularly helpful when clients need to strengthen responsibility, clarify wants, evaluate ineffective behaviors, and develop practical plans for healthier family interactions. Practitioners are encouraged to assess the specific needs of clients before selecting an intervention and to consider combining cognitive restructuring, assertiveness training, responsibility-based self-evaluation, and behavioral planning in family and marital counseling. It is also important for therapists to provide between-session assignments and real-life practice opportunities so that clients can apply new skills in everyday family interactions and maintain therapeutic gains after treatment.

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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

All authors have equally contributed to the research process and the development of the manuscript.

Declaration

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

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