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Comparing the Effectiveness of Cognitive Behavioral Therapy and Compassion-Focused Therapy in Improving Distress Tolerance and Self-Compassion in Women with Experiences of Marital Infidelity

Parisa. Karami[1], Mohammad Hassan. Ghanifar[2*], Ghasem. Ahi[3]

[1] PhD student, Department of Psychology, Birjand Branch, Islamic Azad University, Birjand, Iran
[2] Assistant Professor, Department of Psychology, Birjand Branch, Islamic Azad University, Birjand, Iran
[3] Assistant Professor, Department of Psychology, Birjand University, Birjand, Iran

*** Corresponding author email address**: ghanifar@iaubir.ac.ir

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A B S T R A C T

Objective: Distress tolerance and self-compassion play a significant role in mitigating the harm caused by the experience of infidelity. This study compares the effectiveness of cognitive behavioral therapy (CBT) and compassion-focused therapy (CFT) in improving distress tolerance and self-compassion among women who have experienced marital infidelity.

Materials and Methods: This quasi-experimental study employed a pre-test, post-test, follow-up design with a control group. The study population included women who had experienced infidelity by their spouse and sought counseling and psychotherapy services in Tehran in the year 2021. From this population, using purposive sampling, 45 women were selected based on the study's criteria and randomly assigned to two experimental groups and one control group (15 per group). The first experimental group received cognitive behavioral therapy, and the second received compassion-focused therapy. The control group did not receive any intervention. Data were collected using the Distress Tolerance Scale (Simons & Gaher, 2005) and the Self-Compassion Scale (Neff, 2003). Data were analyzed using repeated measures analysis of variance and SPSS software version 22.

Findings: The results showed that both distress tolerance and self-compassion scores in the cognitive-behavioral and compassion-focused therapy groups were higher in the post-test compared to the pre-test ($p<0.01$). Furthermore, a comparison of the two experimental groups revealed no significant difference in scores of distress tolerance and self-compassion between the groups.

Conclusion: It can be concluded that both cognitive-behavioral therapy and compassion-focused therapy were equally effective in improving distress tolerance and self-compassion among women.

Keywords: *Cognitive Behavioral Therapy, Compassion-Focused Therapy, Distress Tolerance and Self-Compassion, Marital Infidelity*

1. Introduction

The experience of infidelity for couples is considered a potentially painful and distressing event, and each partner who undergoes such experience is likely to report psychological distress, including anxiety and symptoms of depression. The emotional breakdown can be accompanied by many negative emotions (Alexopoulos, 2021; Koessler et al., 2022). According to research findings, couples who have experienced infidelity report intense emotions and experiences similar to those experienced by individuals in mourning; emotions and experiences such as fear, anxiety, despair, demotivation, failure, pessimism, and decreased self-esteem (Koessler et al., 2022). Therefore, if women who have experienced infidelity are unable to alleviate these negative and distressing emotions, all aspects of their lives will be negatively affected, potentially resulting in physical and psychological consequences for them. According to some claims, a lack of psychological capabilities is one of the main factors of failure in emotional relationships and marriage (Heidari Mamadi & Vaziri Yazdi, 2019).

In this context, distress tolerance plays a significant role in repairing the existing damage. Distress tolerance is commonly researched in the field of emotional dysregulation and is defined as a meta-emotion construct, representing the capacity to experience and tolerate negative psychological states (Aslanifar et al., 2019). Distress tolerance is the desire and ability to remain and act positively while refraining from engaging in maladaptive behaviors during periods of physical and emotional stress. From some perspectives, distress is represented as negative emotional states that are often revealed with a tendency to react to escape the negative emotional experience. Individuals with low levels of distress tolerance find emotional turmoil exhausting and unacceptable, consequently striving to soothe this negative emotional state, but often they are unable to focus their attention on anything other than their distress (Elhai et al., 2018).

Compassion is another concept that plays a crucial role in individuals experiencing emotional breakdown and infidelity. Compassion is generally a multi-dimensional construct with four main cognitive, emotional, mindful, and motivational aspects, encompassing four key elements: 1) awareness of suffering (cognitive/empathetic awareness), 2) sympathetic attention (emotional element), 3) the wish to see the relief and alleviation of that suffering (mindfulness), 4) responsiveness and readiness to alleviate that suffering (motivational) (Frostadottir & Dorjee, 2019). Results indicate that the more an individual is subject to emotional abuse and neglect, the less self-compassion they exhibit in dealing with everyday problems, and they are more likely to experience physical symptoms, anxiety disorders and sleep disturbances, social functioning disorders, and increased depression (Benzo et al., 2015; Brophy et al., 2020; Dasht Bozorgi, 2018). Also, these individuals, when faced with different situations, critically judge aspects of their personality that they do not love, instead of supporting themselves in crises, they do not speak gently and calmly about their shortcomings. They resort to self-criticism and attack instead of showing warm and unconditional acceptance to themselves (Akin, 2010; Babaei et al., 2020). Therefore, women who have experienced infidelity are at risk of decreased self-compassion due to their distressing experience. When viewed from the perspective of self-compassion, both oneself and others are deserving of care and attention. This supportive attitude towards oneself is associated with many positive psychological outcomes, such as increased motivation for resolving interpersonal conflicts, constructive problem-solving, marital life stability, less depression, anxiety and perfectionism, and greater life satisfaction (Brophy et al., 2020).

In identifying effective interventions to improve distress tolerance and self-compassion in women who have experienced infidelity by their spouse, cognitive-behavioral therapy (CBT) and compassion-focused therapy (CFT) appear to be effective. In the cognitive-social perspective, all cognitive processes are considered part of psychological pathology, involving incorrect expectations and perceptions of one's self-efficacy, which can lead to anxiety (Cook et al., 2019). Cognitive-behavioral therapy emphasizes that thought processes are as important as environmental influences, aiming to correct irrational beliefs, ineffective convictions, misinterpretations, cognitive errors, sense of control over life, facilitate constructive self-talk, and enhance coping skills (Weiss et al., 2018). In cognitive-behavioral therapy, patients are encouraged to perceive the relationship between their negative self-directed thoughts and unpleasant feelings and their inappropriate behavioral patterns as hypotheses to be tested, using behaviors resulting from negative self-directed thoughts as a basis for evaluating the validity or accuracy of those thoughts (Cheng et al., 2020; Cook et al., 2019).

On the other hand, the basic principles of compassion-based therapy suggest that thoughts, factors, images, and external soothing behaviors should be internalized, and in doing so, the human mind, as it reacts to external factors,

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also calms in the face of these internalizations (Dasht Bozorgi, 2018). In the process of compassion-based therapy, individuals learn not to avoid or suppress their painful emotions, thus they can first recognize their experience and feel compassion towards it (Babaei et al., 2020). The main focus of this therapy is to cultivate a compassionate mind; in fact, the therapist gradually does this by explaining and elaborating the skills and characteristics of compassion to the person (Brophy et al., 2020; Dasht Bozorgi, 2018). For instance, it is not that individuals with self-compassion use fewer words expressing negative emotions when describing their weaknesses (Irons & Lad, 2017). They just experience less anxiety when contemplating their weaknesses. Findings show that self-compassion is associated with less anxiety and depression and higher psychological well-being. Additionally, self-compassion leads to positive emotions. A review study showed that compassion-focused therapy is effective in reducing psychological pathology, especially high self-criticism. In one study, participants were asked to write a self-compassion letter to themselves for one week. They found that this brief intervention increased happiness levels compared to the control group, which had been asked to write about early memories. Various studies have demonstrated the effectiveness of compassion-focused therapy in improving mental health, adaptation to illness, reducing stress and psychological distress, increasing self-care, and reducing fatigue and burnout caused by illness in cancer patients (Babaei et al., 2020). The current study seeks to answer whether cognitive-behavioral therapy and compassion-focused therapy can be effective in improving distress tolerance and self-compassion in women who have experienced infidelity by their spouse.

2. Methods and Materials

2.1. Study Design and Participants

The present research was of a quasi-experimental design, utilizing a pre-test, post-test, and follow-up with a control group. The study population included women who had experienced infidelity by their spouses and were seeking services at counseling and psychotherapy centers in Tehran in the year 2021. From this population, using purposive sampling, 45 women were selected based on the inclusion criteria of the study and randomly assigned to two experimental groups and one control group (15 per group). The first experimental group received cognitive-behavioral therapy (CBT), and the second group underwent compassion-focused therapy (CFT). The control group did not receive any intervention. Participants were asked to respond to questionnaires at three stages: before starting intervention sessions, after the completion of the intervention, and two months thereafter. The sampling method in the first stage was based on purposive sampling, and from among women who had experienced infidelity by their spouses and sought services at counseling and psychotherapy centers in Tehran in 2021, 45 were selected based on inclusion and exclusion criteria. The sample size, calculated with a precision of 0.05, a study power of 80%, and a confidence level of 95%, resulted in 20 individuals per group. Inclusion criteria included women who had experienced infidelity from their spouse, a minimum education level of a high school diploma, age over 20 years, and no acute physical or psychological illness or history of substance addiction. Exclusion criteria included absence from more than two therapy sessions and lack of willingness to continue participation in the sessions.

Participation in this study was entirely voluntary. Before the start of the project, participants were familiarized with the project's details and regulations. The views and beliefs of individuals were respected. Members of both the experimental and control groups were allowed to withdraw from the research at any stage. Furthermore, members of the control group were offered the same intervention as the experimental group in similar therapeutic sessions after the completion of the project, if they were interested. All documents, questionnaires, and confidential records were exclusively accessible to the investigators. Informed consent was obtained from all volunteers. Descriptive data analysis included statistical indicators for each research variable. Inferential statistics employed repeated measures analysis of variance and SPSS software version 22.

2.2. Measures

2.2.1. Self-Compassion

The Self-Compassion Scale is a 26-item tool created by Neff (2003) to measure the level of self-compassion. Responses on this tool range on a 5-point Likert scale from 1 (almost never) to 5 (almost always). Neff (2003) assessed its reliability and validity as appropriate. In this research, the internal consistency of the scale is suitable. Scoring is reversed for some statements and subscales (items 1, 2, 4, 6, 8, 11, 13, 16, 18, 20, 21, 24, and 25). The minimum score is zero, and the maximum is 104, with higher scores indicating greater self-compassion. Neff (2003) validated the psychometric properties of this scale on a sample using

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exploratory and confirmatory factor analysis, confirming its three-factor structure: self-kindness vs. self-judgment, common humanity vs. isolation, and mindfulness vs. over-identification. The Cronbach's alpha coefficient was reported as 0.89, and the retest reliability coefficient with a two-month interval was 0.82. In another study in the Iranian student population, the four-factor structure of the Self-Compassion Scale was examined and confirmed (Movahedrad et al., 2023).

2.2.2. Distress Tolerance

The Distress Tolerance Scale, a self-assessment index for emotional distress tolerance developed by Simons & Gaher (2005), consists of fifteen items and four subscales: tolerance of emotional distress (items 1, 3, and 5), absorption by negative emotions (items 2, 4, and 15), appraisal of distress (items 6, 7, 9, 10, 11, and 12), and regulation efforts to alleviate distress (items 8, 13, and 14). This instrument is scored on a five-point scale, with the minimum and maximum possible scores being fifteen and seventy-five, respectively. Higher scores indicate higher distress tolerance, and lower scores indicate lower distress tolerance. The reliability coefficient for the entire scale was reported as 0.81, and for the subscales, it was respectively 0.72, 0.87, 0.86, and 0.89. Additionally, the scale has been shown to have good criterion and convergent validity. This scale negatively correlates with acceptance of mood and coping strategies using alcohol and marijuana. Cronbach's alpha for the questionnaire was reported as 0.72 for the total score and 0.91, 0.78, 0.79, and 0.94 for the subscales, respectively (Leeuwerik et al., 2020).

2.3. Interventions

2.3.1. Cognitive-Behavioral Therapy Intervention

The cognitive-behavioral therapy process was conducted over 8 90-minute sessions based on the protocol by Hazlett-Stevens (2008) in a group setting (Cheng et al., 2020; Cook et al., 2019).

Introduction to CBT and Assessment of Distress: The first session introduces the participants to the principles of CBT, establishes therapeutic rapport, and assesses each participant's level of distress and their personal experiences with infidelity. This session focuses on setting goals for therapy and introducing the concept of the cognitive model as it relates to their feelings of betrayal and distress.

Identifying Negative Thoughts: Participants learn to identify automatic negative thoughts (ANTs) related to their experience of infidelity and how these thoughts influence their emotions and behaviors. Techniques for recognizing cognitive distortions and the impact of these thoughts on their distress levels are explored.

Challenging and Replacing Negative Thoughts: This session is dedicated to challenging identified negative thoughts and cognitive distortions. Participants are taught to use evidence to dispute these thoughts and to develop more balanced and realistic thoughts, leading to decreased distress.

Coping with Emotions: Focuses on emotional regulation strategies. Participants learn to identify and express their emotions in healthy ways, use relaxation techniques, and engage in activities that improve their mood.

Improving Self-Compassion and Self-Esteem: This session targets the development of self-compassion and improving self-esteem. Exercises are introduced to help participants treat themselves with kindness and understanding, and to recognize their worth independently of their betrayal experience.

Behavioral Activation and Re-engagement: Participants are encouraged to engage in activities that they find enjoyable or fulfilling, to reintegrate positive experiences into their lives, thereby reducing the focus on their distress and promoting well-being.

Addressing Relationship Beliefs and Expectations: This session examines the impact of infidelity on participants' beliefs and expectations about relationships. It encourages reevaluation and adjustment of these beliefs to align more closely with personal values and desires for future relationships.

Consolidation and Relapse Prevention: The final session reviews the skills learned throughout therapy, discusses progress made, and develops a plan for maintaining gains and managing potential future distress.

2.3.2. Compassion-Focused Therapy Protocol

The therapeutic model used in this treatment was broadly based on Gilbert's (2009) therapy package. The therapy sessions consisted of 8 group sessions held once a week for 90 minutes (Babaei et al., 2020; Dasht Bozorgi, 2018).

Introduction to CFT and the Concept of Compassion: The first session introduces the concept of compassion towards oneself and others. It explains how compassion can be a powerful tool for healing from the distress caused by

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infidelity. Participants are introduced to the three-circle model of emotion regulation (threat, drive, and soothing systems).

Developing Mindfulness: Participants learn mindfulness techniques to increase awareness of their thoughts, feelings, and bodily sensations in the present moment. Mindfulness practices aim to create a space between experiences and reactions, facilitating a more compassionate response to personal suffering.

Cultivating Compassion for Self: This session focuses on developing self-compassion. Exercises are introduced to help participants generate a compassionate inner voice to counter self-criticism and to treat themselves with kindness and understanding.

Exploring the Sources of Self-Criticism: Participants explore the origins of their self-critical thoughts, including how these may relate to their experiences of infidelity. Understanding the sources of self-criticism is seen as a step towards developing a more compassionate self-relationship.

Compassionate Imagery and Letter Writing: Participants engage in compassionate imagery exercises and are guided to write a compassionate letter to themselves, addressing their experiences of betrayal and distress with kindness and understanding.

Developing Compassionate Relationships: This session focuses on applying compassion in relationships, including the relationship with oneself and others. Strategies for communicating needs and boundaries in a compassionate manner are discussed.

Practicing Compassion in Daily Life: Participants are encouraged to practice compassion in their daily lives, identifying opportunities to be compassionate towards themselves and others, and reflecting on the impact of these practices on their well-being.

Review and Future Planning: The final session reviews the concepts and practices learned throughout the therapy. Participants share their experiences of implementing compassion-focused strategies, discuss progress, and plan for continuing compassion practices in their lives to maintain their well-being and manage distress.

2.4. Data analysis

This research utilized descriptive statistics (demographic information, mean, and standard deviation) and inferential statistics (multivariate analysis of covariance and variance with repeated measures in the follow-up phase). Before conducting the analysis, assumptions including the Shapiro-Wilk test for normality, Levene's test for homogeneity of variances, Box's M test for covariance matrixes, pre-test and group interaction for homogeneity of regression slopes, multicollinearity, linearity (scatter plots) were examined. Finally, the comparison between cognitive-behavioral play therapy and resilience-based play therapy was analyzed using the Bonferroni post-hoc test in the SPSS software version 26.

3. Findings and Results

The majority of participants in the first experimental group were in the age range of 20-30 years (7 people, 46.66%), in the second experimental group were aged 31 to 40 years (6 people, 40%), and in the control group were aged 46 years and above (7 people, 46.66%). The highest educational level in the first experimental group was high school diploma (7 people, 46.66%), in the second experimental group was associate's degree and bachelor's degree (10 people, 66.66%), and in the control group was high school diploma and below (7 people, 46.66%).

Table 1

Central Indices and Dispersion of Research Variable Scores in Both Experimental and Control Groups

Variable	Group	Pre-test Mean (SD)	Post-test Mean (SD)	Follow-up Mean (SD)
Distress Tolerance	Cognitive-Behavioral	29.800 (3.858)	59.400 (3.601)	60.750 (4.10)
	Compassion-Focused	29.533 (3.943)	60.600 (3.089)	59.30 (3.77)
	Control	29.600 (3.869)	30.133 (2.850)	30.25 (2.21)
Self-Compassion	Cognitive-Behavioral	51.533 (4.627)	105.001 (4.750)	104.20 (4.97)
	Compassion-Focused	51.733 (3.432)	104.533 (3.398)	103.35 (5.74)
	Control	52.600 (4.084)	52.400 (5.552)	52.44 (5.26)

Descriptive indices related to the variables of distress tolerance and self-compassion, differentiated by the three groups, are presented in Table 1.

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Table 2

Results of Normal Distribution Tests and Homogeneity of Variances Tests

Variable	Group	Kolmogorov-Smirnov (DF, Statistic, p)	Levene's Test (DF, Statistic, p)	Mauchly's Test (Statistic, Mauchly's W, p)
Distress Tolerance	Cognitive-Behavioral	15, 0.638, 0.81	40, 1.50, 0.245	3.15, -, 0.16
	Compassion-Focused	15, 0.821, 0.51	-	-
	Control	15, 1.12, 0.16	-	-
Self-Compassion	Cognitive-Behavioral	15, 0.592, 0.87	40, 2.33, 0.18	2.69, -, 0.27
	Compassion-Focused	15, 0.618, 0.84	-	-
	Control	15, 0.781, 0.57	-	-

To assess the significance of the difference between the distress tolerance and self-compassion scores in the two experimental groups and the control group, repeated measures analysis of variance was used. The results of the Kolmogorov-Smirnov test for the research variables indicated that the data were normally distributed. The Levene's test for homogeneity of variances in the experimental and control groups showed equal variances of research variables across the pre-test, post-test, and follow-up stages. Also, the results of the Mauchly's test of sphericity indicated the absence of covariance matrix sphericity among groups, necessitating the use of the conservative Greenhouse-Geisser test.

The results of the multivariate repeated measures analysis of variance among the study groups for distress tolerance and self-compassion variables showed that the between-subjects effect (group) was significant, meaning that at least one of the groups differs from the others in at least one of the variables of distress tolerance and self-compassion. The within-subjects effect (time) for the research variables was also significant, indicating that over time, from pre-test to follow-up, there was at least a change in the mean of one of the variables.

Table 3

Repeated Measures ANOVA for Comparing Pre-test, Post-test, and Follow-up of Distress Tolerance and Self-Compassion in Experimental and Control Groups

Measure	Source of Effect	Sum of Squares	Degrees of Freedom	Mean Square	F	Significance	Eta Squared
Distress Tolerance	Time	119.46	1.13	92.71	148.15	0.001	0.84
	Time*Group	53.994	2.26	17.998	1.872	0.150	0.126
	Group	317.283	2	158.641	16.501	0.000	0.458
Self-Compassion	Time	400.08	1.13	296.70	261.46	0.001	0.90
	Time*Group	16.399	2.26	5.466	0.239	0.869	0.018
	Group	130.814	2	65.407	2.857	0.070	0.128

The results in Table 3 indicate that the analysis of variance for the within-group factor (time) is significant and is significant between groups. These results mean that considering the group effect, the time effect is also significant on its own. Moreover, the interaction between group and time is significant. Additionally, the Bonferroni post-hoc test was used for pairwise comparisons of groups.

Table 4

Bonferroni Post Hoc Test Results for Comparing Distress Tolerance and Self-Compassion

Variable	Group 1	Group 2	Mean Difference	Standard Error	Significance Level
Distress Tolerance	Cognitive-Behavioral	Compassion-Focused	0.46	1.69	1.000
	Cognitive-Behavioral	Control	52.60	1.69	0.001

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	Compassion-Focused	Control	52.13	1.69	0.001
Self-Compassion	Cognitive-Behavioral	Compassion-Focused	0.46	1.69	1.00
	Cognitive-Behavioral	Control	52.60	1.69	0.001
	Compassion-Focused	Control	52.13	1.69	0.001

Results in Table 4 show that both distress tolerance and self-compassion in the cognitive-behavioral and compassion-focused therapy groups were higher in the post-test compared to the pre-test ($p<0.01$). Additionally, a comparison of the two experimental groups showed that the scores of distress tolerance and self-compassion did not significantly differ between the cognitive-behavioral and compassion-focused therapy groups.

4. Discussion and Conclusion

The current study compared the effectiveness of cognitive behavioral therapy (CBT) and compassion-focused therapy (CFT) in improving distress tolerance and self-compassion in women who have experienced infidelity from their spouse. It can be said that both cognitive-behavioral and compassion-focused therapy groups were effective in improving distress tolerance and self-compassion among women who have experienced spousal infidelity. However, the comparison between the cognitive-behavioral and compassion-focused therapy groups showed that there were no significant differences in the scores of distress tolerance and self-compassion between the two groups. This finding is consistent with the results of previous (Alexopoulos, 2021; Babaei et al., 2020; Benzo et al., 2015; Brophy et al., 2020; Cheng et al., 2020; Cook et al., 2019; Dasht Bozorgi, 2018; Frostadottir & Dorjee, 2019; Heidari Mamadi & Vaziri Yazdi, 2019; Movahedrad et al., 2023; Weiss et al., 2018).

To explain this finding, it can be said that cognitive behavioral therapy focuses on changing unhealthy thoughts and behaviors. This method is based on the ideal that daily activities, thoughts, and feelings of a person have a significant impact on their relationships and behaviors. Cognitive-behavioral therapy is conducted with the goal of observing and changing unhealthy thoughts and behavioral patterns. This therapy, through psychological exercises and homework, helps the individual to recognize and change negative and unhealthy patterns. Cognitive-behavioral therapy emphasizes that thoughts, emotions, and behaviors are interconnected, and changing one of these elements can lead to changes in the others. Also, this therapy helps the individual to identify and change the negative and unhealthy patterns formed as a result of the experience of infidelity from their spouse. This therapy helps to counter unhealthy thoughts like "I am not worthy of love" or "no one values me" and replace them with healthy and self-motivated thoughts (Cheng et al., 2020; Cook et al., 2019).

On the other hand, compassion-focused therapy is also a therapeutic process that focuses on the ability to tolerate mistakes and negative internal feelings, aiming to strengthen self-compassion and kindness. This method states that instead of being unfair and harsh to oneself, one should accept oneself with compassion and kindness, understand and take care of their needs. This therapy, through exercises such as compassionate meditation and methods to strengthen self-compassion and reduce self-criticism, helps the person improve their relationship with themselves and have more optimism and satisfaction in life (Babaei et al., 2020). The goal of this therapy is to improve self-compassion and increase the individual's satisfaction and mental health. In this therapy, the primary focus is on developing and strengthening compassion towards oneself and others, pursuing this goal through exercises and techniques that enhance compassion and teach increased self-awareness and awareness of others.

It can be said that both cognitive-behavioral and compassion-focused therapies have been effective in terms of the variable of self-compassion, but cognitive-behavioral therapy had a higher impact compared to compassion-focused therapy in improving self-compassion in women. This finding is consistent with the results of previous (Akin, 2010; Babaei et al., 2020; Benzo et al., 2015; Brophy et al., 2020; Cheng et al., 2020; Cook et al., 2019; Dasht Bozorgi, 2018; Frostadottir & Dorjee, 2019; Irons & Lad, 2017; Leeuwerik et al., 2020; Movahedrad et al., 2023).

In explaining the above finding, it can be said that cognitive-behavioral and compassion-focused therapies can be effective in reducing distress and improving the psychological well-being of women who have experienced infidelity from their spouse. A study conducted in 2018 evaluated the impact of CBT on distress in women who have experienced spousal infidelity. In this study, a group of women participated in six weeks of cognitive-behavioral therapy and compared to the control group, results showed that cognitive-behavioral therapy could significantly improve distress, anxiety, and depression in women who have experienced infidelity. Cognitive-behavioral therapy is an effective method for helping women experience distress

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tolerance after experiencing infidelity. This method provides tools and exercises that help women identify their negative behavioral patterns and thoughts and shift them towards positive and constructive patterns (Weiss et al., 2018).

One of the fundamental principles of cognitive-behavioral therapy is changing misconceptions about oneself, others, and the world. Women who have experienced infidelity may have negative and incorrect beliefs about themselves (e.g., thinking they caused the infidelity), others (e.g., thinking all men are unfaithful), and the world (e.g., thinking no relationship can be safe and reliable). Cognitive-behavioral therapy helps women identify these incorrect thoughts and shift towards positive and realistic thoughts by providing new evidence and facts. In addition, cognitive-behavioral therapy also focuses on changing behavioral patterns. This method helps women recognize the consequences of infidelity and learn how to manage them. For example, women can improve their communication skills and look for constructive solutions to solve their relationship problems. Overall, cognitive-behavioral therapy helps women become more familiar with their feelings of distress and dissatisfaction, review their problematic behaviors, and learn new solutions to better cope with the experience of infidelity and create healthier relationships.

5. Limitations & Suggestions

The results of the research may not be generalizable to other statistical communities as it was limited to women who have experienced infidelity, and the COVID-19 pandemic made data collection from applicants problematic. Due to the COVID-19 pandemic and the onset of a new peak, it was not possible to hold a follow-up session. It is suggested that the present study also be conducted in men, as individuals of different genders have different personality and instinctual characteristics, and therefore, recognizing these differences can lead to quicker preventative actions in case of problems. It is suggested that the present research be repeated in other provinces, as the results of the current study, conducted in Tehran province, may be influenced by lifestyles affected by life in Tehran, where people have numerous occupations and less free time. Thus, conducting research in other provinces and cities may yield different results from the current study. It is also suggested that other methods, such as interviews with psychology professors and consultants, patients, and officials of treatment centers, be used for data collection; as there is a possibility of personal biases of respondents in filling out the questionnaires.

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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 equally contributed in this article.

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