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Comparison of the Effectiveness of Transdiagnostic and Solution-Focused Therapies on Decision-Making Quality in Married Women

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ABSTRACT

Objective: This study aimed to compare the effectiveness of transdiagnostic therapy and solution-focused therapy on the decision-making quality in married women in Isfahan.

Materials and Methods: The research methodology was a quasi-experimental pretest-posttest-follow-up design, and the sample included 48 married women who were purposively selected based on inclusion and exclusion criteria and then randomly assigned into three groups of 16 (two experimental and one control group). While the control group was on a waiting list and did not receive any training, the transdiagnostic experimental group underwent 10 90-minute sessions according to the integrated transdiagnostic therapy protocol by Barlow et al. (2011), and the solution-focused experimental group underwent 8 90-minute sessions according to the protocol adapted from 'Key Concepts in Solution-Focused Therapy' by De Shazer (1985). All three groups filled out the relevant questionnaire at three stages: pretest, posttest, and follow-up. The measuring instrument used in this study was the Akhbari Decision Making Quality Questionnaire (2015). The collected data were analyzed using descriptive statistics (mean and standard deviation) and inferential statistics (analysis of covariance).

Findings: The results showed that both therapeutic groups, compared to the control group, improved decision-making quality; however, transdiagnostic therapy was more effective than solution-focused therapy.

Conclusion: Thus, both therapies can be used to enhance decision-making quality in married women.

Keywords: *Transdiagnostic therapy, Solution-focused therapy, Decision-making quality, Married women*

1. Introduction

Decision-making involves selecting an option from the available choices, which is the main focus of planning (Parsakia et al., 2023), and decision-making quality refers to how an individual perceives and reacts to the responsibility of making decisions (Liverpool et al., 2021; Treffers et al., 2020). Every individual must make decisions

in various aspects of life, and the nature of these decisions will determine their success or failure. Decision-making skills, considered a life skill, enable individuals to select the best solution by realistically understanding their goals and being fully aware of the consequences of available solutions (Cenkseven-Önder, 2012; Kheirkhah et al., 2018). Furthermore, decisions are often linked to the decision-maker's judgment. Thus, decision-making quality can be measured in various fields and through different methods, with high-quality decisions being characterized by doing the right thing, at the right time, with the right people (Parker et al., 2015; Raziee et al., 2022; Treffers et al., 2020). People have different decision-making styles. A decision-making style is a process by which an individual reaches a conclusion about how to approach a problem or topic (Kheirkhah et al., 2018). Decision-making styles include dependent, rational or logical, intuitive, avoidant, and spontaneous, although individuals do not always stick to one style but vary according to the situation and conditions, depending on the environmental circumstances (Cenkseven-Önder, 2012; Parker et al., 2015). Married individuals may make decisions to address marital problems. Some wrong decisions taken by couples facing dissatisfaction in their marital life include infidelity and divorce, which can be highly damaging if not considered carefully, often leading to severe personal, family, and social consequences. Decision-making also plays a significant role in selecting educational fields, choosing a spouse, parenting, and career choices. Moreover, research has shown that high-quality decision-making skills are external manifestations of cognitive development that improve psychological health, happiness, and personal independence (Liverpool et al., 2021) and that there is a bidirectional relationship between positive emotions and decision-making, where positive emotions like happiness influence individual performance and affect their decision-making, which in turn impacts their emotional experiences such as happiness (Bubić & Erceg, 2018; Cenkseven-Önder, 2012; Treffers et al., 2020).

One of the methods that address the emotional process is the integrated transdiagnostic therapy invented by Barlow and his colleagues (Barlow et al., 2010). The transdiagnostic approach is cognitive-behavioral therapy with added emotion regulation to enrich it further so that clients can manage their negative emotions effectively by acquiring necessary skills (Abdi et al., 2013). In transdiagnostic therapy, the belief is that focusing on specific disorder processes limits the understanding of common factors among disorders. Therefore, it is better to emphasize common emotional disorders with a transdiagnostic view (Etamadi, 2018); moreover, given the very high comorbidity of life damages, including individual and couple damages, identifying transdiagnostic therapies can prevent imposing excessive therapy costs and wasting time due to addressing each of these damages separately (Kamrani et al., 2019).

Integrated transdiagnostic therapy, which is based on cognitive-behavioral therapy adjusted for emotions and maladaptive emotion regulation strategies, thus the main foundation in this approach is the emotional experience and response to emotions. This therapy seeks to identify and correct maladaptive emotions so that the regulation of emotional experiences can occur adaptively, thereby facilitating the corresponding processing and, as a result, extinguishing the disproportionate emotional responses to internal and external cues (Wilamowska et al., 2010). It is important to note that in the transdiagnostic approach, emphasis is placed on both emotions and responses to emotions, encompassing all emotions, both positive and negative, because sometimes negative emotions are generated by positive emotions (Barlow et al., 2010). What is considered in transdiagnostics is complete awareness of both positive and negative emotions and learning how to respond correctly to emotions in different and significant situations. Clients learn the three-component model of thought, feeling, and behavior to better recognize their emotions in different situations and, instead of surrendering or avoiding, to experience their emotions more fully and completely. Thus, one of the fundamental skills in transdiagnostic therapy is emotion-focused awareness in the present moment without personal judgment, and understanding other concepts of this therapy is not possible until this skill is fully learned. It also emphasizes the functional nature of emotions and their adaptability, making it easier for the person to tolerate emotions. Therefore, in individuals undergoing transdiagnostic training, the sense of cohesion and cognitive awareness increases (Samaeelvand et al., 2022).

The short-term solution-focused therapeutic approach is another therapeutic intervention invented by Steve de Shazer and Insoo Kim Berg. Solution-focused therapy helps find solutions that are compatible with their perceptions through discussions about solutions; practical solutions that clients discover themselves, leading to a new understanding of themselves and, consequently, cognitive and emotional changes and an increase in their ability to solve or control their problems (Sperry et al., 2006).

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Solution-focused therapists have a non-pathologizing view of the client and help them to seek solutions to their problems. This approach emphasizes the here and now and considers change and transformation inevitable. In this approach, the focus is on aspects of the problem that can change, and the short-term nature of the therapy has made this therapeutic approach very popular (Corcoran & Pillai, 2007; Davarniya et al., 2015; Salimi & Sodani, 2023) and can even yield good results in emergency cases (Lee, 1997) because the solution-focused therapist helps the client to develop exceptions instead of dwelling on problems, i.e., solutions that the client has previously used and found effective, reminds the client of them, tries to view the issue from the client's perspective, and seeks behavioral changes with that view, and thus, in collaboration with the client, constructs solution-focused narratives and emphasizes them (Walter & Peller, 1992); hence, solution-focused counseling has become known as hopeful counseling (Nunnally, 1993).

Empowering women is among the development goals of the current millennium, and psychological distress can lead to adverse family outcomes and impair their crucial roles as spouses and mothers (Goudarzi et al., 2021; Parsakia & Darbani, 2022). Therefore, this study aimed to compare the effectiveness of transdiagnostic therapy and solution-focused therapy on the decision-making quality in married women in Isfahan.

2. Methods and Materials

2.1. Study design and Participant

Given the challenges of selecting participants for such experiments, the selection and screening of individuals were conducted purposively and conveniently, with participants being randomly assigned to groups. Therefore, this study is quasi-experimental in method and applied in purpose. The population of this study consisted of married women from Isfahan, and the sample included 48 married women selected voluntarily based on inclusion and exclusion criteria. All individuals filled out the relevant questionnaire and were then randomly divided into two groups: experimental and control. After obtaining the ethics code identified as IR.IAU.KHUISF.REC.1402.028, while the control group did not receive any training, the transdiagnostic experimental group underwent 10 weekly 90-minute sessions (Abdi et al., 2013; Barlow et al., 2010; Homan, 2016; Kamrani et al., 2019), and the solution-focused experimental group, 8 weekly 90-minute sessions (Cepukiene & Pakrosnis, 2011; Salimi & Sodani, 2023). At the end of the training sessions, both experimental and control groups were post-tested, and a follow-up was conducted after 45 days. Inclusion criteria were being married with at least 10 years of marital life, literacy, no psychiatric disorders or addiction to substances or alcohol, and an interest in voluntarily participating in the research and sharing experiences. Exclusion criteria included concurrent participation in individual, couple, or group counseling sessions, disrupting group training order, not completing group assignments, absence in more than one session, and lack of willingness to participate in or withdrawal from the research.

2.2. Measures

2.2.1. Decision Making Quality

To evaluate participants' decision-making quality, the Akhbari Decision Making Quality Questionnaire (2015) was used. This 23-item questionnaire, designed by Akhbari (2015), includes dimensions such as the accuracy of decision-making, timeliness, economic efficiency, ease, security, and follow-up, and is rated on a five-point Likert scale ranging from strongly disagree (1) to strongly agree (5), allowing for a total score between 23 and 115. The validity and reliability of this questionnaire have been confirmed by many researchers (Kheirkhah et al., 2018; Mikaeilin et al., 2015; Raziee et al., 2022), and a Cronbach's alpha of 0.85 in this study indicates its reliability.

2.3. Intervention

2.3.1. Transdiagnostic Therapy

Session 1 - Introduction and Psychoeducation: This session focuses on introducing the therapy process, establishing therapeutic rapport, and providing psychoeducation about common emotional disorders. Clients are introduced to the concept of transdiagnostic factors that underlie various psychological disorders. The therapist explains how the therapy aims to address these underlying factors rather than focusing solely on the symptoms of a specific disorder.

Session 2 - Identifying Emotions and Triggers: Clients learn to identify and label their emotions accurately, as well as to recognize the external and internal triggers that elicit these emotions. This session employs exercises to enhance emotional awareness and discusses the role of emotions in decision-making and behavior, including the decision to seek extramarital relationships.

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Session 3 - Cognitive Appraisal and Reappraisal: This session introduces cognitive appraisal as a method for evaluating emotional experiences. Clients learn how their thoughts and beliefs about an emotional situation influence their feelings and behaviors. Cognitive reappraisal techniques are taught to challenge and change maladaptive thoughts, reducing the intensity of negative emotions and the desire for infidelity.

Session 4 - Emotional Regulation Strategies: Clients are taught various emotional regulation strategies to manage intense emotions effectively. Techniques such as deep breathing, mindfulness, and distraction are practiced. The session emphasizes choosing appropriate strategies based on the context and the specific emotions experienced.

Session 5 - Understanding and Breaking Emotional Habits: This session delves into the habitual nature of emotional responses and behaviors, including those leading to thoughts of infidelity. Clients learn to identify their emotional habits and the consequences of these habits on their relationships. Strategies for breaking maladaptive habits and forming new, healthier emotional habits are discussed.

Session 6 - Developing Emotional Resilience: The focus of this session is on building emotional resilience to better cope with life's challenges without resorting to harmful behaviors such as infidelity. Techniques include building a support system, enhancing problem-solving skills, and fostering a positive outlook on life and relationships.

Session 7 - Improving Interpersonal Relationships and Communication: Clients learn skills to improve their interpersonal relationships, with a focus on communication techniques that promote understanding and intimacy in the marital relationship. The session covers expressing emotions constructively, active listening, and addressing needs and desires within the relationship.

Session 8 - Relapse Prevention and Maintenance: This session focuses on strategies to maintain progress and prevent relapse into old patterns of emotional dysregulation and thoughts of infidelity. Clients develop a personalized plan that includes cues for recognizing early signs of relapse, strategies for coping with emotional triggers, and ways to maintain emotional stability.

Session 9 - Consolidation and Future Planning: Clients review the skills and knowledge acquired during therapy and discuss their application to future challenges. The session encourages the consolidation of emotional regulation skills and cognitive strategies to sustain improvements in marital satisfaction and emotional wellbeing.

Session 10 - Closure and Evaluation: The final session provides an opportunity for closure and reflection on the therapy process. The therapist and client evaluate the client's progress towards their goals, discuss any remaining challenges, and plan for continued personal growth and emotional health. The importance of ongoing practice of the learned skills to maintain marital harmony and prevent infidelity is emphasized.

2.3.2. Solution-Focused Therapy

Session 1 - Establishing Therapeutic Goals: The initial session is dedicated to building rapport and identifying the client's goals for therapy. The therapist uses solution-focused questions to help clients articulate what they hope to achieve, focusing on their desired future rather than past problems. The concept of looking for exceptions to the problem (times when the problem does not occur or is less intense) is introduced.

Session 2 - Identifying Exceptions: This session delves deeper into the identification of exceptions. Clients are encouraged to recall specific instances when the desire for infidelity was absent or minimized. The therapist helps the client explore what was different about these times and how these exceptions can be used as a foundation for change.

Session 3 - Amplifying Change: Building on the exceptions identified, this session focuses on amplifying positive change. The therapist and client explore small, practical steps that the client can take to increase the frequency of these positive experiences. The session aims to shift the client's focus from problems to solutions and strengths.

Session 4 - Leveraging Strengths and Resources: Clients are encouraged to identify personal strengths, resources, and support systems that can aid in their journey toward their therapeutic goals. The therapist facilitates a discussion on how these assets can be utilized more effectively to enhance the client's relationship and reduce the inclination toward infidelity.

Session 5 - Enhancing Communication Skills: This session is dedicated to improving communication within the marital relationship. Clients learn and practice solution-focused communication techniques, such as expressing needs clearly and positively, listening actively, and providing affirmations to their partner.

Session 6 - Building a Preferred Future: Clients are guided to construct a detailed vision of their preferred future, specifically focusing on their marital relationship. The

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therapist helps the client identify what steps, no matter how small, can be taken towards realizing this vision. The emphasis is on actionable steps that the client feels confident about implementing.

Session 7 - Reviewing Progress and Adjusting Goals: The progress made towards the client's goals is reviewed, and adjustments are made as necessary. This session reinforces the client's autonomy and competence by highlighting the positive changes made and exploring how these changes can be sustained and built upon.

Session 8 - Consolidating Gains and Planning for the Future: In the final session, the focus is on consolidating the gains made during therapy and planning for the future. The therapist and client discuss strategies for maintaining progress, dealing with potential setbacks, and continuing to build a fulfilling and faithful marital relationship. The session ends with a discussion on how the client can continue to apply solution-focused principles in their life and relationship.

2.4. Data Analysis

Descriptive data analysis included statistical indicators for each of the research variables. In the inferential statistics section, repeated measures analysis of variance and SPSS-22 software were used.

3. Findings and Results

Descriptive findings showed that participating women ranged in age from 26 to 65 years, with the majority in the 36-45 age group and the fewest in the 56-65 age group. Regarding education, most participants in all three groups had a diploma level of education. In both the transdiagnostic therapy and solution-focused therapy and control groups, most individuals had been married for 10-19 years. The fewest number of individuals in the transdiagnostic and control groups had been married for 40-49 years, while in the solution-focused therapy group, this duration was 30-39 years.

Table 1 presents the means and standard deviations for the pre-test, post-test, and follow-up stages of the desire for infidelity variable in the research groups.

Table 1

Mean and Standard Deviation of Decision Quality in Research Groups Across Three Time Points

Group	Pre-test	Post-test	Follow-up
	Mean (SD)	Mean (SD)	Mean (SD)
Transdiagnostic Therapy	81.500 (10.539)	107.938 (3.605)	113.375 (21.799)
Solution-Focused Therapy	81.875 (9.251)	102.812 (9.432)	102.437 (9.777)
Control Group	80.875 (9.701)	80.813 (9.530)	80.750 (9.903)

As seen in Table 1, for the decision-making quality variable, there were changes in the post-test and follow-up stages in the therapy group compared to the control group.

Subsequently, the Shapiro-Wilk test (for the normal distribution of variables), Levene's test (equality of variances across groups), Box's M test for equality of variance-covariance matrices, and Mauchly's test for sphericity for the decision-making quality variable were examined. The decision-making quality variable did not have a normal distribution ($p>0.01$), and equality of error variances ($p>0.05$) was not established for all three. Equality of the variance-covariance matrix (via Box's M test) ($p>0.01$) was not established. Also, Mauchly's test for the component of decision-making quality was significant ($p<0.05$), meaning the sphericity assumption for these two variables was not met. In cases where the sphericity assumption is not met, the Greenhouse-Geisser statistic can be used in the final analysis. Repeated measures ANOVA data for the decision-making quality variable are presented in Table 2.

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Table 2

Repeated Measures ANOVA Data for Decision Quality

Variable	Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	F-value	Significance	Eta Squared	Power of Test
Decision Quality	Within-Groups							
	Time	11309.656	1.608	7035.307	110.432	p < .001	.648	1.000
	Time × Group Interaction	5038.927	4.823	1044.842	16.401	p < .001	.451	1.000
	Error (Time)	6144.750	96.453	63.707	-	-	-	-
	Between-Groups							
	Group	10549.682	3	3516.561	11.714	p < .001	.369	1.000
	Error	18011.688	60	300.195	-	-	-	-

Considering the violation of the sphericity assumption, as seen in Table 2, the within-group effect, the time factor (F=110.432, df=1.608, p<0.01), and the interaction of time and group (F=16.401, df=4.823, p<0.01) indicate that there are significant differences over time and in the interaction of time with the group (p<0.01). The partial eta squared for the time factor is 0.648, and for the interaction of time with the group, it is 0.451, with the test power for both factors being 1. These findings suggest that 69.4% and 61.8% of the differences in the decision-making quality are related to the application of the independent variable (therapy method), confirmed with 100% test power.

Also, as observed in Table 2 in the section on the between-group effect, there is a significant difference in the group factor (F=11.714, df=3, p<0.05). This means that the conducted ANOVA showed a significant difference between the experimental groups (both therapy groups) and the control group for this variable. To potentially explore differences between the experimental and control groups pairwise, a Bonferroni post hoc test was conducted, presented in Table 3 for the pre-test, post-test, and follow-up stages.

Table 3

Bonferroni Post Hoc Test Data for Pairwise Comparisons of Research Groups on the Decision-making quality Variable

Stage	Base Group	Comparison Group	Mean Difference	Standard Error	Significance
Time	Pre-test	Post-test	15.594	0.900	p < .001
	Pre-test	Follow-up	-16.891	1.421	p < .001
	Post-test	Follow-up	-1.297	1.404	p = 1.000
Group	Transdiagnostic Therapy	Solution-Focused Therapy	5.229	3.537	p = .867
	Transdiagnostic Therapy	Control	-20.125	3.537	p < .001
	Solution-Focused Therapy	Control	-14.896	3.537	p < 0.01

As seen in Table 3, there is a significant difference between the pre-test stage and the other two stages (p<0.01 or p<0.05). However, there is no significant difference between the post-test and follow-up stages (p>0.05). Also, there is a significant difference between the two therapy groups, transdiagnostic and solution-focused, compared to the control group (p<0.05), indicating the effectiveness of these two therapies on the decision-making quality.

4. Discussion and Conclusion

The current study aimed to compare the effectiveness of transdiagnostic therapy and solution-focused therapy on decision-making quality in married women. The results indicated that both therapies were significantly more effective than the control group in improving decision-making quality, with transdiagnostic therapy showing greater efficacy. Regarding the impact of transdiagnostic therapy on decision-making quality, the findings suggest an increase in decision-making quality in the experimental group compared to the control group. The effectiveness of transdiagnostic therapy in improving decision-making quality can be attributed to its cognitive-behavioral approach that incorporates emotion regulation, enriching the therapy and helping clients manage their negative emotions effectively (Abdi et al., 2013; Barlow et al., 2010; Homan, 2016; Kamrani et al., 2019; Samaeelvand et al., 2022; Wilamowska et al., 2010). This integrated transdiagnostic approach aims to reduce the intensity of negative emotions

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and thoughts, thereby minimizing harm and enhancing individual functioning. In this integrated approach, thoughts, behaviors, and feelings interact dynamically, each playing a role in emotional experience (Samaeelvand et al., 2022; Wilamowska et al., 2010). Transdiagnostic therapy reduces rumination on the cognitive dimension and promotes adaptive emotional adjustment (Barlow et al., 2010; Homan, 2016). Moreover, emotional effectiveness, a process involved in transdiagnostic and trans-theoretical therapies, influences a broad range of psychological pathologies and is defined as the individual's ability to experience and respond effectively to all emotions appropriately based on situational values (Barlow et al., 2010; Homan, 2016; Kamrani et al., 2019). According to Parker and Fischhoff (2005), when an individual needs to make a decision, they must have three skills: evaluate the probabilities related to different outcomes and the pros and cons of each, be aware of illogical emotional effects based on personal values judged against social standards, and consider a combination of the first two skills in the final decision-making process. Emotional regulation plays a fundamental role in having all three skills, especially the second, making it likely that transdiagnostic therapy can enhance decision-making quality. No research was found that directly addresses this topic for comparison with the current study.

In explaining the effectiveness of solution-focused therapy on improving decision-making quality, it can be said that solution-focused therapy, with its non-pathological approach, focuses on the positive aspects of life, resources, strengths, talents, and capabilities instead of concentrating on problems, deficits, disabilities, and diseases (Corcoran & Pillai, 2007; Lee, 1997). Researchers viewed decision-making as a series of specific steps and actions where information plays a crucial role, hence considering decision-making as the final stage of using information. Information technology significantly affects decision-making quality by eliminating time and space constraints, providing better and faster access to information, and ensuring currency (Liverpool et al., 2021; Parker et al., 2015; Raziee et al., 2022). It is not surprising that solution-focused therapy improves decision-making quality. Additionally, solution-focused therapists, by asking exception questions, make clients aware that they have faced similar issues in the past and have managed to resolve them, thus increasing their sense of capability to handle the current situation and reducing their stress. This approach also reminds clients of good past experiences and makes them consider what they were doing during those times that they are not doing currently and what they were avoiding that they are now engaging in (Davarniya et al., 2015; Salimi & Sodani, 2023). Furthermore, by strengthening clients in creating appropriate and structured solutions, solution-focused therapy enhances their sense of self-sufficiency and autonomy (Corcoran & Pillai, 2007). This assessment and structuring of solutions aid clients in making better and higher quality decisions. Additionally, by discovering exceptions, the therapist instills hope in clients to see a better future as achievable (Cepukiene & Pakrosnis, 2011; Salimi & Sodani, 2023). Since discussing the causes of problems and the difficulty of changing them can lead to feelings of helplessness and despair, the miracle question in solution-focused therapy directs clients towards necessary changes and actions to make these happen, thus enhancing their sense of self-efficacy and belief in the possibility of change (Salimi & Sodani, 2023; Walter & Peller, 1992). Therefore, since despair can lead individuals to avoid decision-making or increase their stress, thus heightening their negative emotions and diminishing their positive ones, it is not surprising that solution-focused therapy can improve decision-making quality, although no research was found that directly addresses this topic for comparison with the current study.

5. Limitations and Suggestions

This study has several limitations that should be acknowledged. Firstly, the sample size is relatively small and confined to married women from a specific cultural background in Isfahan, which may limit the generalizability of the findings to other populations or cultural contexts. Additionally, the study's design as a quasi-experimental study with a control group on a waiting list may introduce biases related to motivation or expectations. The reliance on self-reported measures for assessing decision-making quality might also introduce response biases, as participants may not accurately reflect or may underreport their decision-making processes.

Future research could address the limitations of the current study by employing a larger, more diverse sample that includes participants from different marital statuses and cultural backgrounds to enhance the generalizability of the findings. It would also be beneficial to incorporate a longitudinal design to assess the long-term effects of the therapies on decision-making quality. Additionally, using a mixed-methods approach that includes qualitative interviews could provide deeper insights into the cognitive

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and emotional processes influencing decision-making. Exploring the impact of individual differences, such as personality traits or emotional intelligence, on the effectiveness of transdiagnostic and solution-focused therapies could further refine our understanding of therapeutic outcomes.

The findings of this study have practical implications for psychological therapy and marital counseling. Given the effectiveness of both transdiagnostic and solution-focused therapies in enhancing decision-making quality, these approaches should be considered as viable options in therapeutic settings, particularly for those facing significant life decisions or marital difficulties. Training programs for therapists might incorporate modules on these therapy approaches, emphasizing skills in emotion regulation and the fostering of positive life aspects. Moreover, policymakers and mental health professionals could use these results to develop workshops and programs aimed at improving decision-making skills among couples, potentially aiding in the reduction of marital conflicts and decisions leading to adverse outcomes such as infidelity or divorce.

Authors' Contributions

Authors contributed equally to this article.

Declaration

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

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

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

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