Research Article

The Effectiveness Of Compassion-Focused Therapy Training On Reducing Aggression And Improving Quality Of Marital Relationships Of Married Women Aged 30-50

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Abstract:

Background: The present study was aimed at evaluating the effectiveness of compassion-focused therapy in reducing aggression and improving the quality of marital relationships in married women aged 30-50.

Method: The research method was quantitative and in the quantitative section the RDAS scale was used to assess the quality of marital relationships and the Buss-Perry AQ was utilized to measure aggression in a pre-test-post-test design in the statistical population. Then, among the qualified women, 15 people were undergone compassion-focused group therapy as the experimental group and 15 people were randomly selected as a control group. The experimental group was treated with compassion-focused group therapy. Afterward, a post-test was performed for both groups (experimental and control). The data obtained from the answers to the questionnaires were analyzed by SPSS 23 software using Multivariate analysis of covariance test.

Results: The results indicated that compassion-focused therapy was effective in aggression and the quality of marital relationships of married women. The results of multivariate analysis of covariance on the scores of aggression components confirmed the effectiveness of compassion-focused therapy training on verbal aggression, physical aggression and anger subscales, but its effectiveness in hostility subscale was not confirmed.

Conclusion: The results of multivariate covariance test on the scores of marital relationship quality components confirmed the effectiveness of compassion-focused therapy training in agreement and satisfaction subscales, but its effectiveness in the subscale of coherence was not confirmed.

Keywords: Compassion-Focused Therapy, Aggression, Marital Relationship, Group Therapy.

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Background:

People experience a wide range of family experiences during the time they grow up and develop. Some people have been raised in relatively stable families characterized by love and healthy relationships. Others have experienced events such as instability, contradiction, and chronic problems. Through these experiences, individuals learn a wide range of lessons (direct and indirect) about their personal relationships. The family plays a significant role in people learning from relational dynamics such as love, respect, honesty or lack of these dynamics. One of the concerns of our modern society is the quality of marital relationships. If the quality of marital relationships in families decreases, families and society will experience a lot of problems. The study of couples' relationships helps to clarify the structural frameworks in which couples' relationships are formed. In most societies, examining the quality of marital relationships plays a

key role in assessing the overall quality of family relationships. It is important to study the quality of marital relationships of all couples in the society, but in the meantime, paying attention to the lifestyle of married women and their way of life can be very effective in promoting the health of families, present and future generations. The issue of the quality of marital relationships has attracted the attention of many researchers in recent decades. The study of the quality of marital relations investigates the effect of all issues on increasing agreement, satisfaction and coherence (1). Couples' aggression has been considered since the 1990s given the importance of the family institution in today's society, its connection with quality of life and its influence on various aspects, including physical and mental health (2). Compassion includes a set of emotional, cognitive, and motivational elements and is based on the ability to create opportunities for development and change with kindness and care. Gilbert considers kindness as the basis of compassion with a deep awareness of the suffering of individuals and other living beings, as well as the desire and effort to get rid of it (3). Compassion is easily misunderstood and confused with love and kindness. It refers to the most intense and at the same time powerful emotional sensitivity and awareness, attention to the suffering of oneself and others, the ability to discover the causes of suffering, wisdom and commitment to healing and prevention of suffering. Clearly, the main point of this definition is to face suffering instead of avoiding it and to develop a desire to relate to suffering and its causes. What is important is that compassion is sought not only to get rid of suffering but also to promote the well-being of individuals as a purpose of treatment (4). The proposed model of compassion in compassion-focused therapy derives many of its structures from previously-conducted research. However, the principle used to define compassion is rooted in ancient wise rites. But there is a standard definition used in compassion-focused therapy. Given the role of compassion in increasing courage and redesigning individual standards, it can be argued that this treatment helps the person to be more courageous compared to the past, challenge the vicious cycle of self-criticism and having high-level expectations of oneself, and redesign realistic standards and achievable expectations that do not involve difficulty and trouble with a new, empathetic look at oneself (5).

Methods:

Sample and Sampling Method

A convenience sampling method was used for this research and the reason for using the convenience sampling method is that the intended sample is specific and if researchers do not use this method, research may be difficult or impossible (1). And the sample of this study, after administering the AQ and the quality of marital relationships questionnaires, was selected according to the scores of the questionnaires in the pre-test stage, and finally out of 43 women 30 women were accepted. Subsequently, 15 women were randomly assigned to the experimental group and the control group. One of the inclusion criteria for the study was that all the subjects should be married females and aged 30-50. All subjects in the pre-test obtained a score above 29 in the quality of marital relationships test and a score below 87 in the AQ test and were found to have no disorder other than aggression.

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Research Instruments

BPAQ and Buss & Perry AQ

In the present study, aggression is assessed by the revised version of Buss-Perry AQ (1992)(6). This questionnaire is a self-report tool that includes 29 items and has 4 subscales called: physical aggression, verbal aggression, anger and hostility. The answers in this questionnaire are calculated based on a 5-point Likert scale, and the two items, i.e. 9 and 16, are scored inversely, and the total aggression score is obtained by summing the scores of the subscales.

Reliability and Validity

This questionnaire was developed by Buss and Perry in 1992 (6) and has 29 items and measures the four factors, verbal aggression (5 items), physical aggression (9 items), anger (7 items), and hostility (8 items). The scoring method is based on the Likert scale from 1 (extremely uncharacteristic of me) to 5 (extremely characteristic of me). The score of items 24 and 29 is inverse. The total score is the sum of the total scores of the statements and ranging from 29 to 145. High scores indicate more aggression. In Mohammadi's study, the reliability of the AQ was analyzed by three methods, including Cronbach's alpha, test-re-test and split-half, and the reliabilities obtained in this study amounted to 89%, 78% and 73%, respectively. The validity of this questionnaire was examined through convergent and concurrent validity index and factor analysis. To assess the reliability of the aggression questionnaire, the results of Mohammadi's research on measuring the reliability using the test-retest method showed that the value of reliability coefficients for aggression subscales varies between 0.61 and 0.74. Furthermore, the total retest coefficient of the questionnaire was 0.78. The internal consistency using Cronbach's alpha index indicated that the range of Cronbach's alpha coefficients for aggression questionnaire factors was between 0.71 and 0.82 and Cronbach's alpha index for the entire questionnaire was 0.89. The convergent validity of the AQ shows that there is a significant relationship between the aggression factors. The range of coefficients among the factors is between 0.38 and 0.60. In addition, each of the factors has a high correlation with the whole questionnaire, the minimum and maximum of which are 0.68 and 0.81, respectively.

RDAS Scale (Relationship Dyadic Adjustment Scale)

The questionnaire was developed by Busby, Crane, Larsen, and Christensen (7).

Table 1- AQ Dimensions and its Items

Sub-scales	Alpha coefficients	Items	Number of items
Verbal aggression	0.74	4-6-14-21-27	5 items
Physical aggression	0.79	2-5-8-11-13-16-22-25-29	9 items
Anger	0.71	1-9-12-18-19-23-28	7 items
Hostility	0.82	3-7-10-15-17-20-24-26	8 items

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The original form of this scale was developed by Spinner (1979) based on the theory of Lewis and Spinner (1979) regarding the quality of marital relationships. Fincham, Bradbury, and Beach (2000)(8), after proposing their theory of marital quality, also introduce this questionnaire as an appropriate tool to assess the quality of marital relationships. This 14-item questionnaire, which is based on the original 32-item questionnaire provided by Spinner (1976), is scored on a 6-point scale from 0 to 5, with “completely agree” being scored as 5 and “completely disagree” being scored as 0. This tool consists of 3 sub-scales of agreement (6 items), satisfaction (4 items) and coherence (4 items), which together show the marital quality score and high scores indicate a higher quality of marital relationship. Confirmatory factor analysis has confirmed three-factor structure of the questionnaire in the United States and has shown its validity (7). The reliability of the questionnaire in Holist and Miller’s study (2005) using Cronbach's alpha method has been reported to be ranging from 0.80 to 0.90. Yousefi examined the psychometric characteristics of this questionnaire and reported the following results:

The results obtained from the factor analysis with an oblique rotation approach showed three factors of marital relationship quality (agreement, satisfaction and coherence) in Iranian society and they showed to be well-fitted to the factor model using confirmatory factor analysis. The internal consistency reliability coefficients, including Cronbach's alpha and half-split, were satisfactory for 14 items and three factors in the whole questionnaire (with values of 0.91, / 89 and .860, respectively). Moreover, t-test analysis indicated that there was no difference between men and women in the factors and also multivariate analysis of variance showed that there was no difference between the eight age groups in terms of marital quality.

Results:

Descriptive Statistics

In order to analyze the data collected, analytical statistics are used in two forms descriptive and inferential statistics. Initially, using descriptive statistics, demographic status and characteristics of the respondents are identified, and then the descriptive findings related to the main research variables are analyzed. Afterwards, in the inferential statistics, the causal relationships among the existing variables in the conceptual model of the research are examined. The analysis of statistical data in this study is conducted by S.P.SS23 software. This section, it is attempted to present all the statistical operations performed on the questionnaire in the form of a specific category. In this part, the general characteristics of the respondents, age, level of education, etc. are examined and then the questionnaire items and hypotheses are analyzed.

As is seen in Table 2 and the chart below, in this sample 2 people in the control group (13%) and 3 people (20%) in the experimental group are under 35 years old; four people (27%) in the control group and 5 people (33%) in the experimental group are between 35 and 40 years old; five people (33%) in the control group and 6 people (40%)in the experimental group are between 41 to 45 years old; four people (27%) in the control group and 1 person (7%) in the experimental group are between 46 and 50 years old.

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Table 2- Frequency Distribution of Age

		Control group			Experimental Group		
		n	%	%*	n	%	%*
Age	Under 35 years old	2	13	13	3	20	20
	35-40	4	27	40	5	33	53
	41-45	5	27	67	6	40	93
	46-50	4	33	100	1	7	100
	Total	15	100		15	100	
Level of Education	Under-diploma education	3	20	20	1	7	7
	High school diploma	4	27	47	4	27	34
	Associate degree	2	13	60	3	20	54
	Bachelor's degree and higher	6	40	100	7	46	100
	Total	15	100		15	100	
Occupational status	Employee	9	60	60	7	47	47
	Employer	1	7	67	0	0	47
	Unemployed	5	33	100	8	53	100
	Total	15	100		15	100	

*Cumulative percenatge

Therefore, most of the respondents in the control group and the experimental group in this sample are between 41 and 45 years old and a small percentage of the control group is under 35 years old and a small percentage of the experimental group is between 46 to 50 years old.

In this sample, 3 people (20%) in the control group and 1 person (7%) in the experimental group have under-diploma education; four people (27%) in the control group and 4 people (27%) in the experimental group have high school diploma; two people (13%) in the control group and in 3 people (20%) the experimental group have an associate degree; six people (33%)in the control group and 7 people (40%) in the experimental group have a bachelor's degree or post-graduate education. Therefore, most of the respondents in the control group and the experimental group have a bachelor's degree or post-graduate education and a small percentage of the control group has an associate degree and a small percentage of the experimental group has an associate degree.

In this sample, 9 people in the control group (60%) and 7 people in the experimental group (47%) are employees; one person (7%) in the control group is an employer; five people (33%) in the control group and 8 people in the experimental group (53%) are unemployed. Therefore, most of the respondents are employees in the control group and unemployed in the experimental group, and a small percentage of the control group and the experimental group is employers.

The normal distribution of scores obtained by the sample groups in the population was assumed and in order to test the normality of the distribution of scores, the Kolmogorov-Smirnov test was used.

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Table 3- Results of Kolmogorov-Smirnov test on normality of the distribution of aggression scores and its components

Variables	Groups	Test statistic	p value	F*	Significance level
Total aggression	Experimental	0.189	0.157	0.381	0.542
	Control	0.188	0.161		
Verbal aggression	Experimental	0.166	0.200	3.378	0.077
	Control	0.127	0.200		
Physical aggression	Experimental	0.131	0.200	3.956	0.057
	Control	0.158	0.200		
Anger	Experimental	0.93	0.200	0.050	0.824
	Control	0.192	0.116		
Hostility	Experimental	0.136	0.200	3.127	0.088
	Control	0.139	0.200		

* Levene's test

Table 4- Results of Kolmogorov-Smirnov test on normality of the distribution of marital relationship quality scores and their components

Variables	Groups	Test statistic	p value	F*	Significance level
Total quality of marital relationship	Experimental	0.149	0.200	0.149	0.702
	Control	0.172	0.200		
Agreement	Experimental	0.110	0.200	0.733	0.399
	Control	0.144	0.200		
Satisfaction	Experimental	0.169	0.200	3.831	0.060
	Control	0.155	0.200		
Coherence	Experimental	0.106	0.200	0.225	0.639
	Control	0.108	0.200		

* Levene's test

It is known that the null hypothesis in the Kolmogorov-Smirnov test is that the data follow the normal distribution and the opposite hypothesis is that the data does not follow the normal distribution. According to the results of the above analysis and considering the *p* value, which is greater than 0.05 in all variables, as a result, the null hypothesis is not rejected, i.e. the data follow the normal distribution.

As it is known, the null hypothesis in the Kolmogorov-Smirnov test is that the data follow the normal distribution and the opposite hypothesis is that the data does not follow the normal distribution. According to the results of the above analysis and considering the *p* value, which is greater than 0.05 in all variables, as a result, the null hypothesis is not rejected, meaning that the data follow the normal distribution.

Before performing multivariate analysis of covariance, Levene test was used to evaluate the equality of variances, since the variances of the dependent variables must be the same in both experimental and control groups.

As shown by the results in table 3, in the aggression variable as well as in all four

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subscales, including verbal aggression, physical aggression, anger and hostility, the significance level is greater than 0.05; therefore, the variances are equal and it is acceptable to use the analysis of covariance for the research data and the reliability of the results is confirmed.

As the results in Table 5 indicate, for the quality of marital relationships and also in all three subscales including agreement, satisfaction and coherence, the significance level is greater than 0.05; Therefore, the variances are equal and it is acceptable to use the analysis of covariance for research data and the reliability of the results is confirmed.

The results of examining the homogeneity of regression score slopes are shown in Tables 5 and 6.

As the results in Table 4-3 show, the value of F for the aggression variable and all the three subscales is higher than 0.05 and is not significant. It can be concluded that the null hypothesis is not rejected and the regression slope homogeneity assumption is met; also, it is acceptable to use the analysis of covariance for the research data.

As indicated by the results in Table 5, the value of F for the quality marital relationships and all five subscales is higher than 0.05 and is not significant, so it can be concluded that the null hypothesis is not rejected and the regression slope homogeneity assumption is met. Moreover, it is acceptable to perform covariance analysis for research data.

Results of Hypothesis Testing

Main Hypothesis 1: Compassion-focused therapy training is effective in reducing aggression in married women aged 30-50 years referring to a counseling center.

The statistical findings indicated the effectiveness of compassion-focused therapy training in reducing aggression in the experimental group compared to the control group in the post-test.

Table 5- Examining the homogeneity of aggression slope scores and their components

Interaction of group with:	F	Mean squares	Significance level
Total aggression * group	21.643	805.133	0.051
Verbal aggression * group	7.691	34.202	0.062
Physical aggression * group	3.754	87.546	0.086
Anger * group	7.616	82.117	0.061
Hostility* group	2.455	28.063	0.105

Table 6- Examining the homogeneity of the slope of scores for marital relationship quality and its components

Interaction of group with:	F	Mean squares	Significance level
Total marital relationship quality * group	30.935	527.768	0.051
Agreement * group	7.242	76.235	0.093
Satisfaction * group	11.633	68.080	0.071
Coherence * group	15.566	60.695	0.062

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After examining the effect of pretest on the dependent variable and according to the calculated f coefficient, there is a significant difference between the adjusted means of aggression scores of the participants in terms of group membership of the experimental group and the control group in the post-test phase (f = 28.891). Therefore, the first hypothesis is confirmed. Compassion-focused therapy training had an effect on reducing aggression in the experimental group after the test and so the level of aggression decreased in the experimental group. The size of this effect in the post-test stage was 0.517.

Although much research has been conducted to reduce aggression, very little research has been performed on the effect of compassion-focused therapy training on reducing aggression. In fact, no consistent findings were observed, but the results obtained by other researchers suggest the effectiveness of compassion-focused therapy on aggression-related components. By teaching compassion-focused therapy which is followed by an increase in the willingness dimension (openness to suffering), and also by teaching the characteristics of a kind person and the kindness dimensions (wisdom, strength, warmth and responsibility) and with an increase in the sense of sympathy, empathy and tolerance for distress, the level of aggression decreased in them.

Main hypothesis 2: Compassion-focused therapy training is effective in improving the quality of marital relationships in married women aged 30-50 years referring to the counseling center.

The statistical findings obtained in this study showed the effectiveness of compassion-focused therapy training in improving the quality of marital relationships in the experimental group compared to the control group in the post-test. After examining the effect of the pretest on the dependent variable and according to the calculated coefficient F, a significant difference is observed between the adjusted means of marital relationship quality scores of participants in terms of being a member of the experimental group or control group in the post-test stage (f = 29.450, p=0. 000). Therefore, the second hypothesis is confirmed. Compassion-focused therapy training has also had an effect on improving the quality of marital relationships in the experimental group after the test, and hence, the quality of marital relationships in the experimental group has increased. The size of this effect in the post-test stage was 0.522.

Despite the fact that much research has been conducted to improve the quality of marital relationships, the effect of compassion-focused therapy training on improving the quality of marital relationships has been rarely investigated. In fact, the findings were not consistent with these results, but the results obtained by other researchers indicate the effectiveness of compassion-focused therapy on the components related to quality of marital life, such as marital satisfaction and quality of marital life of couples. By teaching compassion-focused therapy to the experimental group, followed by an increase in sensitivity to suffering, empathy, sympathy and tolerance of distress, the quality of marital relationships has increased.

Sub-hypothesis 1: Compassion-focused therapy training is effective in reducing the dimensions of aggression (verbal aggression, physical aggression, anger, hostility) in married women aged 30-50 years referring to the counseling center in Isfahan.

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The statistical findings indicate that the compassion-focused therapy training has a significant effect on verbal aggression, physical aggression and anger in married women aged 30-50 years referring to the counseling center and has reduced these subscales. But for the hostility subscale, compassion-focused therapy training did not have a significant effect on hostility in married women aged 30-50 referring to the counseling center and did not reduce hostility. For the verbal aggression subscale, ($f = 11.962$ and $P < 0.05$), the effect size was 0.441. Statistical power close to 1 indicates the very high statistical accuracy of the test and the adequacy of the sample size. The difference between the scores of the two groups indicates that in general, the interventions had a significant effect on improving the verbal aggression subscale.

For the subscale of physical aggression, we had $f = 5.367$ and $P < 0.05$. The effect size was 0.187. The difference between the scores of the two groups indicates that in general, the interventions had a significant effect on improving the subscale of physical aggression.

And for the anger subscale ($f = 7.615$ and $P < 0.05$), the effect size was 0.238. The difference between the scores of the two groups indicates that in general, the interventions had a significant effect on improving the anger subscale.

And for the hostility subscale we had $f = 0.140$ and $P < 0.05$. A significance level higher than 0.05 indicates that in general, the interventions did not have a significant effect on improving the anger subscale.

During the compassion-focused therapy sessions, verbal aggression in the sample group showed more changes compared to all the other components; and during this training course, the participants learned to avoid judging others, and their sensitivity to suffering increased; their level of empathy and sympathy increased. During the treatment sessions they also practiced mindfulness, so it is concluded that all of these components are effective in reducing verbal aggression.

Since in this period the characteristics of a wise person were described and practiced, and as mentioned in previous sections, anger is a feeling or emotion that arises from resentment and annoyance and is a response to certain situations and verbal aggression has also reduced them, which could in turn cause anger, so their level of anger reduced. With the decline of anger and verbal aggression that usually is the beginning of arguments, the frequency of arguments has decreased in them, and as a result, the amount of physical aggression has decreased.

As explained earlier, hostility implies prejudice, resentment, and animosity toward others, as every person has their own lifestyle, and eight sessions were not enough to motivate and change their lifestyle; moreover, since only one of the couples attended the meetings and there was no opportunity to resolve their long-standing grudges, so their level of hostility had not changed much.

Sub-hypothesis 2: Compassion-focused therapy training is effective in improving the quality of marital relationships (agreement-satisfaction-coherence) in married women aged 30-50 years who referring to the counseling center in Isfahan

The statistical findings indicate that compassion-focused therapy training has a significant effect on improving the quality of marital relationships (agreement and satisfaction) in married women aged 30-50 years referring to the counseling center and

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has reduced these subscales. But for the coherence subscale, compassion-focused therapy training did not have a significant effect on coherence in married women aged 30-50 referring to a counseling center and did not improve coherence.

For the subscale agreement, we had f = 6.311 and P <0.05 and the effect size was 0.202. Statistical power was close to 1, indicating the very high statistical accuracy of the test and the adequacy of the sample size. Furthermore, for the subscale satisfaction we had f = 27.57 and P <0.05, and the effect size was 0.524; and for the coherence subscale we had f = 1.232 and P <0.05.

As previously explained, agreement in this study means altruism and self-sacrifice, and with compassion-focused therapy, their sensitivity to suffering as well as empathy and sympathy has increased, and finally their level of agreement has enhanced. Coherence refers to feeling emotionally close to each other, as well as the amount of time they spend and the commitment couples have to each other; hence, given that these people each had their own lifestyle that was created over time and only the wives attended in our sessions and their spouses did not take part in these meetings, so their lifestyles did not change much culturally, economically and socially with only eight sessions. Finally, they did not spend much time together and their coherence did not change significantly.

Discussion

The family is the smallest social unit. In order for this institution to be successful in creating a healthy society, enough attention must be paid to its aspects and dimensions. Usually in family therapy systems, special attention is paid to the couple and their relationship, because it is believed that the couple as the main foundations of the family structure can be the source of any change in the family. Families in which the couple understands each other and has a good quality of marital relationship have a better function and play their role better. Nowadays, marital communication has become more and more the focus of spouses 'expectations of each other to satisfy their psychological and social needs, and many therapists consider communication skills training as the first step to improving couples' performance because communication problems are the most common complaint for which couples seek help. Aggression, which causes harm to others, arises from the instinct to fight. Women may also commit physical violence in the family, but it is clear that women’s violence is more limited and much less likely to cause lasting physical harm (10). Therefore, persistence and physical injury are characteristics of male violence. Women often commit verbal and psychological violence through behaviors such as constant grunting or humiliating their husbands. However, in some cases, women’s physical violence (mothers and stepmothers) against children has been reported. Self-compassion exercises emphasize physical relaxation, mental relaxation, self-compassion and mindfulness, which will play an important role in calming the mind, reducing stress and negative thoughts. Research evidence demonstrates that self-compassion also increases emotional resilience, as people with higher levels of this personality trait are less likely to suppress or have mental rumination. Although CFT is often used as an independent treatment, its methods are designed in such a way that therapists with different therapeutic approaches can use them. When we see compassion as more than just an emotion or value, and understand compassion as an evolved motivation that creates a structure for effective action, we can see how incorporating compassion into

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the equation can be useful in many situations.

Conclusion

We can imagine how including compassion in evidence-based approaches can improve our good clinical practice. Cognitive treatment based on compassionate mind facilitates emotional change in order to care for and support oneself, increases acceptance of discomfort, and reduces emotional distress. This treatment enables the person to be more relieved and in control. Compassionate mind therapy rather than resolving internal disputes, helps to change people by creating care, paying new attention to oneself, and suggesting compassionate inner processes. These changes can be interpreted as a kind of physiological-psychological-neurological therapy (10). On the other hand, because compassion-based cognitive therapy is associated with a kind of meditation and physical relaxation, it can be used as a factor in improving the quality of life and reducing aggression.

- It is suggested that compassion-focused therapy training be studied on other structures related to the family system for the psychological well-being of Iranian families.

- It is recommended that compassion-focused training be compared with other approaches in future research.

- A comparison of this approach with other approaches including acceptance and commitment-based therapy in reducing aggression and improving the quality of marital relationships in women can also be investigated.

- Conducting research with subjects realized in other cultures, according to the different cultural contexts of our country is recommended.

- In order to control the effect of the therapist's personality and experience on the research results, replication of research by other researchers is suggested.

- It is also suggested that researchers use a variety of diagnostic tools in the future to obtain more reliable results.

- The present study was performed in the form of group therapy. Therefore, it is suggested that this approach be implemented and the results are analyzed individually.

- It is suggested that further research be conducted on a larger sample to make it more generalizable

- Compassion-focused therapy training should also be used to reduce aggression and improve the quality of marital relationships in men.

- The use of compassion-focused therapy is recommended in clinics and cultural centers.

- Applying compassion-focused therapy training to reduce aggression and improve the quality of marital relationships in men and women who experience a lot of negative emotions in the relationship is recommended.

- Increasing the treatment time to better implement the treatment techniques of this approach and have a greater impact on group members is suggested.

- Applying this or other approaches in the form of educational and treatment programs for married men and women is recommended that can play a major role in improving the quality of their marital relationships and reducing aggression.

References

1. Marina Zanella Delatorre, Adriana WagnerORCID. (2020), Marital Quality Assessment: Reviewing the Concept,

[Downloaded from intjmi.com on 2026-11-01]

[DOR: 20.1001.1.23222913.2022.11.1.2.3]

Instruments, and Methods, Journal of Marriage & Family Review, 56(3).

2. Cuppage, J., Baird, K., Gibson, J., Booth, R., & Hevey, D. (2018). Compassion focused therapy: Exploring the effectiveness with a transdiagnostic group and potential processes of change. British Journal of Clinical Psychology, 57(2), 240-254.

3. Gilbert, P. (2009). Introducing compassion focused therapy. Journal of Advances in Psychiatric Treatment, 15, 199–208.

4. Dennis Tirch, et al. (2016). *Compassion-Focused Therapy for Act Therapists*, translated by Daneshmandi, S, et al., Isfahan, Kavoshiar. 2 ed.

5. Araghian, Shima and Nejat, Hamid and Touzandehjani, Hassan and Bagherzadeh Golmakani, Zahra (2020) Comparing the effectiveness of quality of life therapy and compassion-focused therapy on the quality of interpersonal relationships and distress tolerance in women with marital conflict. Journal of Fundamentals of Mental Health, 22 (3). pp. 190-201.

6. Buss, A.H., & Perry, M. (1992). The Aggression Questionnaire. Journal of Personality and Social Psychology, 63, 452-459

7. Busby, D.M., Christensen, C., Crane, R.D., & Larson, J.H. (1995). A revision of the Dyadic Adjustment Scale for use with distressed and non-distressed couples: Construct hierarchy and multidimensional scale. Journal of Marital and Family Therapy, 21(3),289–308

8. Fincham, F. D., & Bradbury, T. N. (1987). The assessment of marital quality: A reevaluation. *Journal of Marriage and the Family*, 797-809.

9. Azizi, A., Mohammadkhani, P., Foroughi, A. A., Lotfi, S., & Bahramkhan, M. (2013). The validity and reliability of the Iranian Version of the Self-compassion Scale. Iranian Journal of Clinical Psychology, 2(3), 17-23.

10. Gilbert, P. (Ed.). (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. Routledge.

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