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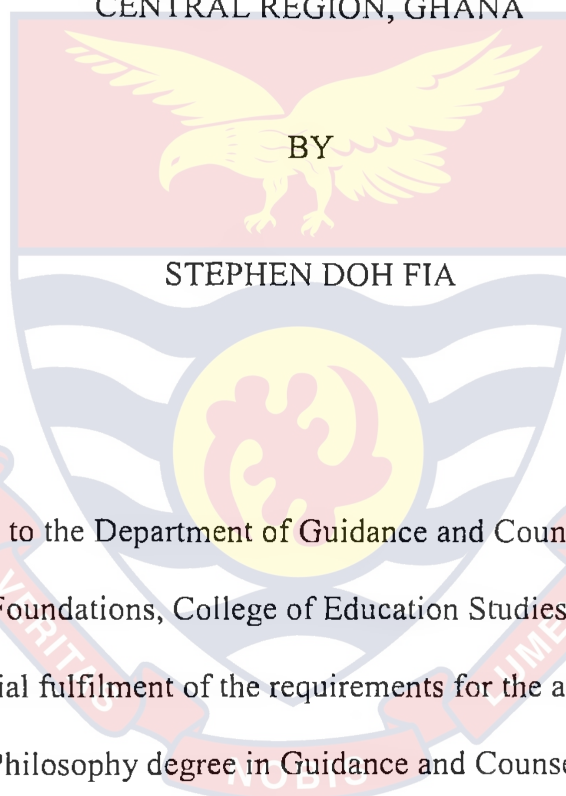
EFFICACIES OF INTEGRATIVE BEHAVIOURAL COUPLE THERAPY (IBCT) AND COGNITIVE BEHAVIOURAL THERAPY (CBT) IN REDUCING MARITAL DISTRESS AMONG PENTECOSTAL CHRISTIAN COUPLES IN CENTRAL REGION, GHANA



BY

STEPHEN DOH FIA

Thesis submitted to the Department of Guidance and Counselling of the Faculty of Educational Foundations, College of Education Studies, University of Cape Coast, in partial fulfilment of the requirements for the award of Doctor of Philosophy degree in Guidance and Counselling

AUGUST 2018

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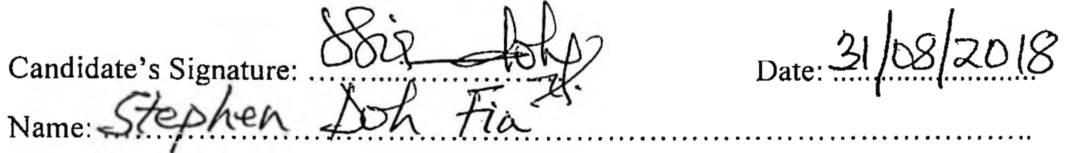
DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.



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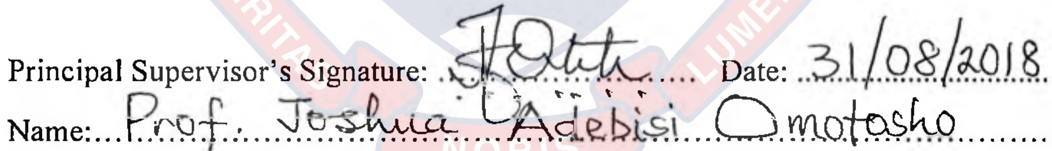
Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.



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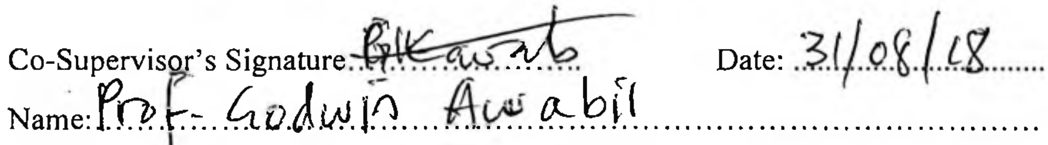

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ABSTRACT

The level of marital distress in Ghana has become an issue of concern to stakeholders as distressed couples are resorting to separation or divorce. The purpose of this study was therefore to ascertain whether using Integrative Behavioural Couples Therapy (CBT) and Cognitive Behavioural Therapy (IBCT) as intervention strategies could reduce marital distress of Christians in the Cape Coast Metropolis of Ghana. The study was carried out using the pre-test, post-test, control group design, a type of quasi-experimental research. The researcher selected 60 respondents who were severely distressed out of 215 married couples using a compendium of instruments on Conceptualising and Measuring "Healthy Marriages" for Empirical Research and Evaluation Studies (Task One Part II), developed by Carrano, Cleveland, Bronte-Tinkew and Moore (2003). Participants were put into three groups of 20 each, two for the treatment groups (CBT and IBCT) and the third one for the control group. A purposive sampling technique was used to select married couples while simple random sampling procedure was used to place the respondents into the three groups. Data was analyesd using descriptive and inferential statistics. The study revealed that IBCT and CBT therapies were found to be effective in reducing marital distress in the Cape Coast Metropolis. Also, it was found out that the level of marital distress of participants reduced further with Integrative Behavioural Couples Therapy (IBCT) as compared to using Cognitive Behavioural Therapy (CBT). The study recommended that marriage counsellors should resort to the use of Integrative Behavioural Couples Therapy (IBCT) and Cognitive Behavioural Therapy (CBT) in assisting married couples out of marital distress and other challenges confronting married couples. The Ghana Psychological Association, the Ghana Psychological Council, the Counsellors Association of Ghana and the Christian Council of Ghana should intensify the use of Integrative Behavioural Couples Therapy (IBCT) and Cognitive Behavioural Therapy (CBT) in assisting clients out of challenges.

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A thesis of this kind owes much to a number of people. In the first place, we know the words "thank you" is familiar, but I utter them with a profound sense of gratitude to my supervisors, Prof. Joshua Adebisi Omotosho of the Department of Guidance and Counselling, and Prof. Godwin Awabil, the Director of the Counselling Centre of the Faculty of Educational Foundations, University of Cape Coast. I thank them for reading through the manuscript and making very useful, constructive, objective and invaluable corrections and suggestions.

I also wish to record my unqualified gratitude to the Head of Department, Guidance and Counselling, Rev. Fr. Dr. Anthony Nkyi, the Dean of the Faculty of Educational Foundations, Prof. Eric Nyarko-Sampson, Dr. Bakari Dramanu Yusuf and all the Faculty members for their encouragement, support and contributions in diverse ways. I am also very grateful to my research assistant, Mr. Enoch Ewoenam Tsey, for his unfathomable support. Special thanks go to Prof. Joseph Ghartey Ampiah (the Vice Chancellor), Prof. Frederick Ocancey, Dr. Asamoah Gyimah, Prof. Prosper Deku, Prof. Emmanuel Kofi Gyimah, Dr. Lebbeaus Asamani and Mr. Kyeremeh Dabone for various roles played towards the success of this work. Iam finally grateful to my family for their support.

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DEDICATION

To all the Lecturers in the University of Cape Coast, University of Education, Winneba and teachers across the globe.

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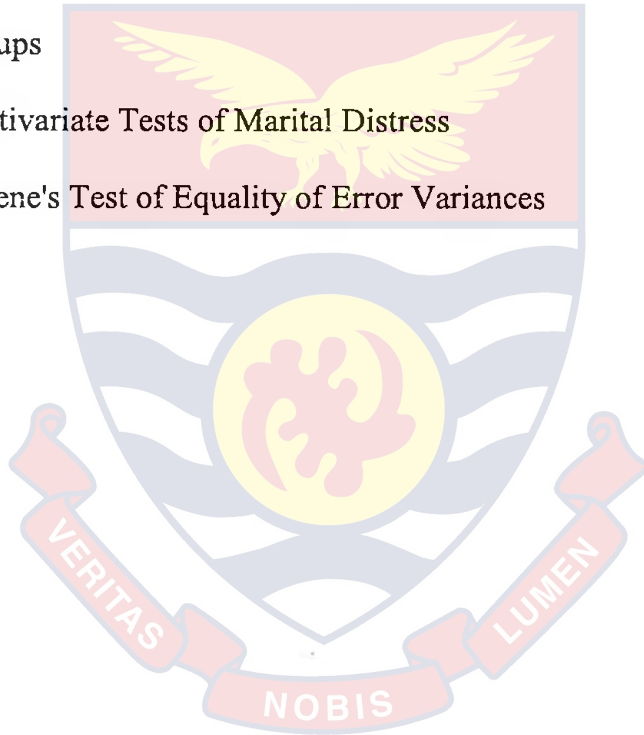

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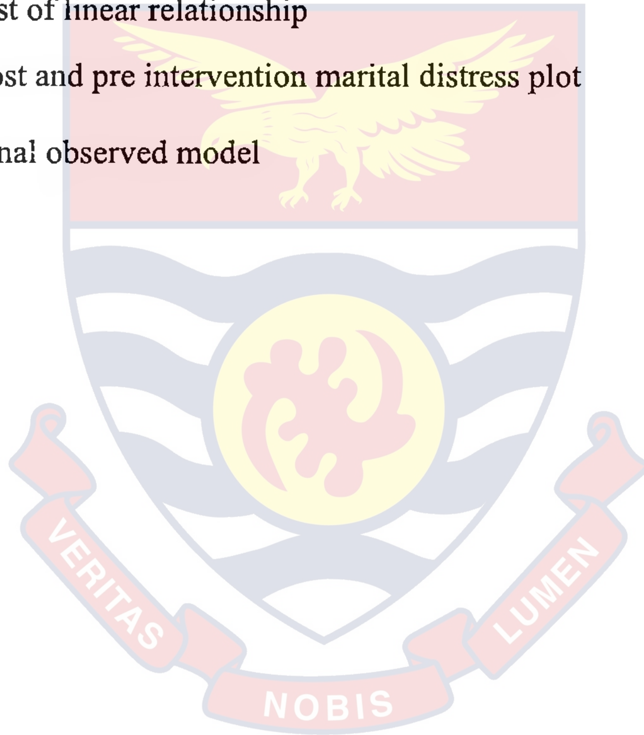

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CHAPTER ONE

INTRODUCTION

Background to the Study

Marriage is a union between a man and a woman who agree to marry each other and have gone through the necessary rites recognized by the society and are publicly pronounced as husband and wife. Marriage, according to Ayisi, as cited in Kyalo (2012), is the means by which a man and a woman come together to form a union for the purpose of procreation. For every marriage to be legal, certain requirements have to be fulfilled, and it should be preceded by certain customary observances. People marry for companionship, support, prestige, sexual satisfaction and procreation. Marriage is to give the couple joy, peace and also assist them to attain other objectives in life (Antiri, 2010). Marriage is also a life-long commitment that restrains self-centeredness, self-indulgence and self-gratification. It is one relationship that effectively prepares and conditions couples for community. By restraining self-centeredness and promoting love for one another, marriage becomes the foundation for social order (Feder, 2017).

According to Chen (2018), married people live longer, are healthier, have fewer heart attacks and other diseases, have fewer problems with alcohol, behave in less risky ways, have more satisfying sex and become much more wealthy than single people. Further, humans cannot live on earth outside the environment of a

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home. In fact, the very foundation of society is the home. Marriage is that divine union between a man and a woman who love each other, and who have welded their lives together so long as they both shall live. It is the cement that holds society together (Purves, 2015).

Many marriages, however, are saddled with numerous problems that threaten the survival of the relationship (Olayinka, 1990). Many couples suffering from distress in their relationships are frustrated, dissatisfied, disappointed and often regret being married (Neubeck & Neubeck, 1997). These problems or challenges have led to separation and divorce of many couples. Although most of these marriages were contracted religiously, divorce and separation became the end product. This has led to an increase in divorce rate of marriages in the country (College Press, Ghana Web, 2016). Many factors have combined to affect the institution of marriage thus causing many problems which both young and old married couples must contend with.

Marital distress can be defined as the state of tension or stress between married partners as the couple perform their roles. The fact that two people agree or plan to live together as husband and wife calls for different expectations and hopes, some of which might be fulfilled while others remain unfulfilled. Since couples are humans, it is natural to expect that there will be differences in opinions, values, needs, desires and habits of everyday living (Olayinka, 1990).

According to Bradbury, Fincham, and Beach (2000), marital distress continues to number among the most frequently encountered difficulties. The divorce rate in America continues to hover around 50%, with half of these divorces

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occurring in the first 7 years of marriage. Rates of marital distress in married couples are approximate 20% of couples at any time, with marital satisfaction decreasing considerably over the first decade of marriage (Bradbury, Fincham, & Beach, 2000). This constitutes a major threat to sustainability of peace and stability in societies.

According to Tolorunleke (2008), marriage should be an exciting and beautiful adventure and the relationship between husband and wife is intended to get better with every passing day or year. However, little things can slip into the relationship and when these things are not properly handled, they can cause friction and eventual separation between the marriage partners that may widen over the years (Okafor, 2002). Information from electronic media, magazines, newspapers, court proceedings and observations reveals that marital instability abounds in the society today and this is due largely to marital distress that couples experience in the process of trying to perform their marital roles as demanded by society (Association for Advancement of Behaviour Therapy, 1998).

According to Association for Advancement of Behaviour Therapy (1998), approximately 50% of first marriages end in divorce, one of life's most stressful events. Even for those marriages that do not end in divorce, many are characterized with unhappiness. For example, it has been estimated that approximately 20% of all married couples experience marital distress, or are discontent with their marriages, at any given time. Despite the risk associated with marriage, almost 90% of the population chooses to marry at least once, and nearly 75% of divorced

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individuals choose to remarry (Association for Advancement of Behaviour Therapy, 1998).

According to the American Association for Marriage and Family Therapy (2002), people in distressed marriages feel fundamentally dissatisfied with their marriages. Most frequently, couples with high levels of marital distress fight a good deal and their fights do not lead to resolution, but simply a sense of being worn out. People stop doing good things for each other, stop communicating, and things tend to go from bad to worse. Again, there are frequent arguments that do not get resolved, there is loss of good feelings and loss of friendship, lack of desire for sex and vitality are all evidences that such a marriage is under distress. Other signs, such as contempt, withdrawal, violence, and a complete loss of connection signal that a marriage is in desperate trouble and that it is at high risk of divorce (American Association for Marriage and Family Therapy, 2002).

Although couples become unhappy with their marriages for a variety of reasons, there are several recurring themes that are frequently associated with marital distress. The most frequent problem reported by unhappy couples is poor communication. Spouses often feel that their partners are making excessive demands or requesting much more than they could give. Other spouses feel that their partners are too withdrawn or do not share or open up enough. Finally, distressed spouses often avoid talking about problems in their relationships because they end up arguing and fighting with each other. These communication problems often result in spouses feeling bad about themselves, their partners, and their relationships. Couples need to create a nurturing relationship in their marriage

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which can be done by communicating their feelings of love, admiration, likes and dislikes to each other. Good communication brings understanding that leads to unity and harmony in marriage (Crosby, 1985).

Melgosa and Melgosa (2005) argued that communication is the centre of interpersonal relationships and also the manner by which messages are exchanged, resulting in satisfaction and happiness or alternatively causing hurt and resentment. Without effective communication between couples, there will be tension, mistrust, less sharing, less intimacy, holding strongly to one's opinions and a sense of isolation. There is the need for right and decodable signals to be sent and well received by both partners involved in the marital relationship. This is how couples can prevent or manage marital distress in their homes.

Another cause of marital distress is unrealistic expectations that spouses may hold about marriage or about each other. For example, spouses may believe that their partners should know what they are thinking and feeling without asking. In addition, distressed spouses are likely to have negative explanations for their partners' behaviour. For example, distressed spouses are likely to blame their partners for anything bad that occurs in the relationship (Association for Advancement of Behaviour Therapy, 1998).

Lack of intimacy or loving feelings between spouses is another cause of marital distress. Although the strong emotions associated with courtship naturally decline over time in relationships, many spouses become upset when they observe such a decline. They may perceive this natural decline as a loss of loving feelings, which is then often associated with a decrease in demonstrations of affection and

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decreased sexual activities. Other difficulties reported by distressed couples include specific problem topics, such as money management, jealousy, conflicts over values, and problems with in-laws. Other spouses become distressed when confronted with negative life events, such as the death of a family member or a serious illness. Marital distress is mostly caused by the inability of the couples to meet each other's sexual needs, and especially the inability of the family heads to provide both economic and social needs of the family (Tolorunleke, 2008).

According to Kramer (1995), distress in marriage can have one or more root causes. Some of the more common causes observed by marriage counsellors and researchers included unrealistic expectations, lack of consideration, respect, or appreciation, lack of open affection or public acknowledgment of love, fear of intimacy, too much-or not enough-dependency. In furtherance, Kramer (1995) reported that inflexible gender roles serves, wanting partners to change, believing that being in love means you can say or do anything to your partner, unfulfilled sex life, financial instability, inability to forgive, problems with in-laws and family involvement, inability to fight fairly or deal with anger and inability to communicate effectively were other root causes of marital distress.

Over the last decade, considerable research findings have come out suggesting that marital distress has a strong relation to an individual's level of mental and physical problems. Marital distress can have a major impact on the relationship and on the psychological, as well as the physical, well-being of each spouse. Moreover, evidence is beginning to appear that indicate that marital distress

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is not only correlated with, but also has a causal role in, the generation and maintenance of individual psychopathology (Whisman & Uebelacker, 2006).

The consequences of marital breakdown cannot be overemphasized. Breakdown of marriages brings untold hardship to children especially when parents become irresponsible. Children may have to fend for themselves. Those who are not ready to toil and have things the "hard way" may resort to robbery and prostitution and other social vices in order to earn a living.

Divorce also brings difficulties to the single parent and their children. (Neubeck & Neubeck, 1997). Some of these children may drop out of school, end up doing menial jobs and often fall prey to unscrupulous men and women who exploit them for their own selfish interest. Such children who drop out of school may only increase the illiteracy rate in the country with its attendant problems. When this commitment labeled "marriage" is reduced to nothing more than a mere contract between two consenting persons, or worse just another option, it ceases to restrain our self-centered passions. Self-centeredness harms not only that relationship but also others as well, until it spreads throughout society (Alan & David, 1988).

Evidence indicates that individuals who have problems in their marriages are more likely to have a variety of psychological problems, including depression and alcoholism (Whisman & Uebelacker, 2006). Compared to individuals who are married and getting along with their spouses, both men and women who are in distressed marriages are more likely to be clinically depressed. Whisman and Uebelacker (2006) further evaluated associations between marital distress and

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Diagnostic and Statistical Manual of Mental Disorders (DSM) Axis I psychiatric disorders in a U.S. population-based survey of married individuals. They found that marital distress was associated with broad classifications of anxiety, mood, and substance use disorders and with all narrow classifications of those specific disorders except for panic disorder. The strongest associations obtained were between marital distress and bipolar disorder, alcohol use disorders, and generalized anxiety disorder.

Studies have also shown that marital distress leads to poorer treatment outcome in the treatment of problems such as depression, anxiety, and substance use disorders and in relapse following treatment (O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998; Whisman, 2001). Distressed spouses are also more susceptible to physical health problems. Violence is also another problem facing spouses in their relationships. Almost one third of all married couples will experience violence at some time in their marriage, with distressed spouses being at greater risk (Association for Advancement of Behaviour Therapy, 1998).

Behavioural problems in children are more common in families in which their parents are distressed. A number of studies have found that children who are exposed to marital distress, particularly to violence, are at greater risk for their own emotional problems (Mechanic & Hansell, 1989; Emery & O'Leary, 1982; Hetherington, Cox, & Cox, 1982; Peterson & Zill, 1986). Children living in high conflict two-parent families manifest more social, emotional, and behavioural problems than children living in single parent families with minimal conflict (Hess & Camara, 1979; Rutter, 1971).

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According to Makhmoor (2017), Integrated Behavioural Couples Therapy (IBCT) is an effective approach used to solve problems of distressed couples who face adjustment problems due to differences in their personalities. Makhmoor (2017) further asserts that IBCT provides effective outcome for marital distress because it offers acceptance based techniques to manage troublesome personality differences between spouses. Further, when couples become dissatisfied with the relationship, they seek therapy, where professional counsellors are expected to assist them to streamline issues in their relationships in order to bury their differences and forge ahead in the relationship. It is therefore hoped that couples who are taken through this therapy will accept and tolerate each other as a way of reducing or avoiding marital distress in their relationships.

According to Halford (2011), Cognitive Behaviour Therapy (CBT) is a simple idea that our unique patterns of thinking, feeling, and behaving are significant factors in our experiences, both good and bad. Since these patterns have such a significant impact on our experiences, it follows that altering these patterns can change our experiences. CBT therefore aims to change our thought patterns, the beliefs we may or may not know we hold, our attitudes, and ultimately our behaviour in order to help us face our difficulties and more effectively strive towards our goals.

The founder of CBT is a psychiatrist named Aaron Beck, a man who practiced psychoanalysis until he noticed the prevalence of internal dialogues in his clients, and realized how strong the link between thoughts and feelings can be. He altered the therapy he practiced in order to help his clients identify, understand, and

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deal with the automatic, emotion-filled thoughts that arise throughout the day (Martin, 2016). Thus, marital distress clearly has a pervasive effect on individual problems, and thus, it behoves on clinicians and researchers to focus on treating individuals to screen for couple distress as well as address it, if present.

In Ghana, it has been realized that the Church has been hit by the issue of divorce and some marriages have ended up in divorce whiles others are also facing serious marital challenges. The Senior Pastor of the Tema Community Four branch of the Central Assemblies of God Church, Reverend David Nabegmado, for example, indicated that divorce rates in churches are becoming alarming and need urgent attention (Nabegmado, 2016). He therefore urged the churches to counsel couples regularly, especially after marriage, to ensure that divorce cases were reduced. Nabegmado indicated that much attention was given to counselling on courtship, but that ended right after the couples had taken their marriage vows. This shows the need for interventions to help deal with marital challenges. It is against this backdrop that this study is being conducted.

The focus of this study, therefore, was to ascertain whether using Integrated Behavioural Couples Therapy and Cognitive Behavioural Therapy as intervention strategies could reduce marital distress in Ghana.

Statement of the Problem

Despite the benefits couples and society derive from marriage, the survival of many marriages is threatened. Many marriages in Ghana are ending on the rock as a result of the distress that many couples go through daily. Many couples are becoming dissatisfied and frustrated in their relationships and this is leading to high

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rates of divorce. Anim (2013) citing Bramlett and Mosher's (2001) stated that one fifth of first marriages ended within 5 years and one third ended within 10 years. The report estimated that at any given time, approximately 20% of all married couples go through marital distress and the distress is so prevalent that one finds it difficult to assign a particular reason or factor to the phenomenon. Similarly, Alhassan (1997) had the conviction that many marriages in Ghana could best be described as distressed, unhappy, and in discord, but these had not yet ended in divorce. Therefore, understanding marital distress, its dynamics and effects and developing effective solutions, have caught the attention of many mental health workers.

Amuzu (1997) further observed that women sustain injuries as a result of marital violence which includes cuts, broken bones, concussions, miscarriages, as well as permanent injuries such as damage to joints, partial loss of hearing or vision, scars from burns, knife wounds and even death. The rate at which marriages are being dissolved is alarming. The Greater Accra Head Office of Legal Aid Ghana, recorded interesting but startling statistics that at least 40% of marriages registered annually in the Region break up within a spate of 14 months. According to the Head of Registry of Legal Aid, the number of females who apply for separation every week far outweighs that of their male counterparts (College Press, Ghana Web, 2016). Reports from Accra Metropolitan Assembly (AMA) indicated that a total of 4,080 divorce cases were recorded in Accra alone from 1998 to 2016. According to the Accra Metropolitan Assembly, the marriages divorced were mainly customary ones and occurred between 2006 and 2013. Only the law courts have

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records of divorce in relation to ordinance marriage while the AMA keeps records of customary marriages and divorces (AMA, 2016). The Head Pastor of Lighthouse Chapel International, Dag Heward-Mills, lamented over the increasing spate of divorce in the country when the Ghana Statistical Service reported that nearly 600,000 marriages contracted in Ghana have collapsed, more than three times the divorce cases of England and Wales put together in 2012 (College Press, Ghana Web, 2016).

The Central Region of Ghana is chosen for this study because of the high divorce rate in the Region. According to Zimbi (2013), "In the Central Region of Ghana alone, the contracted marriages of 2007, 2006 and 2005 were 85, 113, 91 respectively, but the average number of divorce in the same region is 4 in every week. This means that, an average of 16 marriages break-up in every month and a total average of 192 registered marriages break-up in the Central Region of Ghana each year. This figure of 192 divorces as against 85, 113 or 91 contracted marriages in a particular year is truly alarming, and this calls for a stricter look at the marriage institution once again."

There have been some researchers in the Ghanaian setting on marriage. Most of such researchers focused on child marriage, marital satisfaction, socio-economic and psychosocial factors and the effects of divorce (Andam, 2012; Sarfo, 2014; Dzadey, 2015; Froko, 2016; Osei, 2017).

Furthermore, most of the researches were qualitative studies while the quantitative studies make use of the descriptive survey design. However, the few studies that made use of quasi-experimental design seem to be foreign research

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works only. Generally, psychological theories and therapies have been developed to assist people going through psychological, social and personal challenges. Some of these therapies have been used elsewhere to see how effective they are in handling human concerns. The researcher is of the view that it is necessary to test these therapies to see how effective they are in handling human concerns in Ghana. However, most of the studies seen so far did not test psychological theories/ therapies to see how useful they are in solving human concerns such as marital distress. It is based on this fact that the researcher intends to test the efficacy of IBCT and CBT in reducing marital distress in the Central Region of Ghana by making use of the quasi-experimental design.

The focus of this study was to ascertain whether using Integrated Behavioural Couples Therapy and Cognitive Behavioural Therapy as intervention strategies could reduce marital distress in the Central Region of Ghana.

Assumptions of the Study

This study is based on the following assumptions:

1. Couples who are distressed in their marriages are equally dissatisfied with the relationship.
2. Most couples who are distressed do consider the option of separation or divorce.
3. Distressed couples are likely to have health challenges or suicidal thoughts.
4. Separation or divorce brings untold hardships to the single parent and children

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5. The consequences of divorce such as school dropout and increased social vices affect national growth and development.
6. Reducing marital distress using ICBT and CBT will make couples more satisfied in their marriage thereby preventing separation or divorce. This will put couples together to bring up responsible children who will contribute their quota towards national development.

Purpose of the Study

The purpose of this study was to ascertain whether using Integrated Behavioural Couples Therapy and Cognitive Behavioural Therapy as intervention strategies could reduce marital distress among Pentecost Christian couples in Ghana. Specifically, the researcher wishes to attain the following objectives:

1. To determine the effectiveness of Integrated Behavioural Couples Therapy (IBCT) and Cognitive Behavioural Therapy (CBT) on marital distress
2. To determine the influence of gender on the marital distress of participants in IBCT and CBT.
3. To determine the influence of age on marital distress of years in participants in IBCT and CBT.
4. To ascertain the influence of length of years in marriage on marital distress of participants in IBCT and CBT.

Hypotheses

The following hypotheses guided the conduct of the study:

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H_0 1: There is no significant difference in the effectiveness of the interventions (CBT and IBCT) on marital distress among Christian couples in the Cape Coast Metropolis.

H_1 1: There is a significant difference in the effectiveness of the interventions (CBT and

IBCT) on marital distress among Christian couples in the Cape Coast Metropolis.

$H_0$2: There is no significant difference in the effectiveness of IBCT in reducing marital distress among Christian married couples as compared to CBT.

$H_1$2: There is a significant difference in the effectiveness of IBCT in reducing marital distress among Christian married couples as compared to CBT.

$H_0$3: There is no significant difference in the effect of the interventions on the various dimensions of marital distress.

$H_1$3: There is a significant difference in the effect of the interventions on the various dimensions of marital distress.

H_0 4: There is no significant difference in marital distress with regard to gender.

H_1 4: There is a significant difference in marital distress with regard to gender.

H_0 5: There is no significant difference in marital distress with regard to age of the participants.

H_1 5: There is a significant difference in marital distress with regard to age of the participants.

H_0 6: There is no significant difference in marital distress with regard to length of years in marriage.

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H_1 6: There is a significant difference in marital distress with regard to length of years in marriage.

Significance of the Study

It is hoped that the results of this study will possibly provide suggestions that will reduce marital distress in Ghana. Churches, Governmental and non-governmental organizations that promote stable marriages may find the result of this study useful. Traditional leaders and other stakeholders who are interested in peaceful society may also find the result useful. It is also believed that when marriages become very stable, the increasing spate of social vices may reduce drastically making society a safer place of habitation. Finally, marriage counsellors might have extra material that they will use to assist couples going through distress in their marriages in order to promote marital satisfaction as a way of preventing separation and divorce. The study might also act as a source of material for further studies.

Delimitations

This study is restricted to only Integrative Behavioural Couple Therapy (IBCT) and Cognitive Behavioural Therapy (CBT). The study focused on married couples in Central Region only. The sample was drawn from Pentecostal churches in Cape Coast for the sake of convenience. The experiment of the two theories was practiced only on severely distressed couples based on their scores on the instrument used. As an experiment, this research focused mainly on the relationships between known variables.

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Limitations

Generally, questionnaires are self-report methods of collecting data where people answer questions because they feel they are forced to respond and not really report what they are going through. The generalizability of the study might be affected because there is no way of telling how truthful a respondent is. Also people might read differently into each question and respond to the items based on their own interpretation of the questions. Such respondents might respond to the items superficially. The use of this instrument does not also capture the changes of emotion, behaviour and the feelings of the respondents. In using the therapies, the participants initially had difficulties in understanding the therapies but this was resolved during the second session when further explanations and illustrations were made. Also, some participants reported late for some of the sessions but this was improved in the subsequent meetings.

Definition of Terms

Marital distress

Marital distress, as used in this study refers to the stress, conflicts, difficulties, and other challenges that couples go through that make them feel unhappy, worried and upset in the marital relationship.

Marriage

Marriage, as used in this study, is limited to the union between the opposite sex and not between the same sexes.

Couple

A man and a woman who are legally married and are living together

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Intervention Strategies

An activity aimed at modifying or assisting people to overcome certain difficulties or challenges in their lives or their relationships

Organisation of the Study

This study had five chapters. Chapter One comprised the background to the study, statement of the problem, assumptions of the study, the purpose of the study, research questions, hypotheses, significance of the study, delimitation of the study, limitations of the study, definition of terms and the organization of the study.

Chapter Two reviewed related literature on the concept of marriage, theories of marriage, marital distress, causes of marital distress, effects of marital distress, reducing marital distress, integrative Behavioural Couple Therapy, Cognitive Behavioural Therapy. Among other reviews were stages of Counselling using Integrative Behavioural Couple Therapy and Cognitive Behavioural therapy and the role of counselling in reducing marital distress.

Chapter Three comprised the research methods for the study. This included the research design, population, sample and sampling techniques, data collection instrument, validation of instrument, data collection procedures and data analysis. Chapter Four was made up of the results and discussions while Chapter Five dealt with the summary, findings, conclusion, recommendations and suggestions for further study.

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CHAPTER TWO

LITERATURE REVIEW

Overview

The purpose of this study was to ascertain whether using Integrated Behavioural Couples Therapy and Cognitive Behavioural Therapy as intervention strategies could reduce marital distress among Pentecost Christian couples in Ghana. This chapter covered the review of related literature which focused on the conceptual review, theoretical review and empirical studies. Specifically, the conceptual review covered the following sub-topics:

1. The concept of marriage
2. Marital distress
3. Causes of marital distress
4. Effects of marital distress
5. Managing marital distress
6. Marital distress and gender
7. Marital distress and age
8. Marital distress and length of marriage
9. The role of counselling in reducing marital distress

The theoretical review covered the following sub-topics:

1. Theories of marriage

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2. Cognitive Behavioural therapy
3. Integrative Behavioural Couple Therapy
4. Counselling clients with Integrative Behavioural Couple Therapy
5. Counselling clients Cognitive Behavioural therapy

The empirical review covered the following sub-topics;

1. Effectiveness of IBCT
2. Effectiveness of CBT
3. Summary

CONCEPTUAL REVIEW

The concept of marriage

The definition of marriage varies according to different cultures. In some cultures, marriage is recommended or considered to be compulsory before pursuing any sexual activity. When defined broadly, marriage is considered culturally universal. According to Haviland, Prins, McBride and Walrath (2011), marriage, also called "matrimony" or "wedlock," is a socially or ritually recognised union or legal contract between spouses that establishes rights and obligations between them and their children, and between them and their in-laws, as well as society in general. Marriage is therefore seen as a form of a relationship that is not limited to the couples only but also the entire family of the married couples. However, Macdonald (1977) is of a contrary view as he sees marriage as "the ceremony, act, or contract by which a man and a woman become husband and wife" (p. 25). Hubpages (2016) however, rejects Macdonald (1977)'s stance by stating that marriage is "the approved social pattern whereby two to more persons established a family" (p. 3).

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Hubpages (2016)'s stance was also supported by Mark and Blankenhorn (2001) who were of the view that marriage as a social institution, is a relation of one or more men to one or more women that is recognised by custom or law and involve certain rights and duties, both in the case of the parties entering the union and in the case of the children born of it. This involves not only the right to conceive and rear children, but also a host of other obligation and privileges affecting many people.

The real meaning of marriage is the acceptance of a new status, with a new set of privileges and obligations, and the recognition of this new status by others. A legal marriage legitimises a social status and creates a set of legally recognised rights and duties. Marriage is one of the oldest socially recognised institution and essential for the procreation of children and satisfaction of sexual urges (Hubpages, 2016). In different societies, there are different methods of marriages. Some societies allow a male to marry only a single female whereas in other societies, a man is allowed to have more than one wife. Similarly, some societies will not allow a woman to have more than one husband whereas other societies will not mind a woman having more than one husband (Zeitzen, 2008). In a study done in Nairobi by (Dodoo, 1998), marriage in sub-Saharan Africa was said to be either polygamous or monogamous. Monogamy refers to the marriage structure in which there is one spouse at a time (Bumi, 2014). This type of marriage largely follows biblical or Christian principles. Polygamous marriage involves polygyny and polyandry. Polygyny is a marriage structure in which a man is simultaneously married to more than one wife. This type of marriage is mostly common among

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people belonging to the Islamic faith. Polyandry is the marriage structure in which a woman is simultaneously married to more than one husband. In some cases the parents arrange the marriage whereas in others, the men and women arrange their marriage (Bumi, 2014).

Marriage may be considered in terms of two opposing views, namely the Conjugal and Revisionist Views. According to the Conjugal View of marriage, marriage is the union of a man and a woman who makes a permanent and exclusive commitment to each other; the type that is naturally (inherently) fulfilled by bearing and rearing children together. The spouses seal (consummate) and renew their union by conjugal acts (that is, acts that constitute the behavioural part of the process of reproduction), thus uniting them as a reproductive unit. Marriage is valuable in itself, but its inherent orientation to the bearing and rearing of children contributes to its distinctive structure, including norms of monogamy and fidelity. This link to the welfare of children also helps explain why marriage is important to the common good and why the state should recognise and regulate it. The Revisionist View is of the opinion that marriage is the union of two people (whether of the same sex or of opposite sexes) who commit to romantically loving and caring for each other and to sharing the burdens and benefits of domestic life. It is essentially a union of hearts and minds, enhanced by whatever forms of sexual intimacy both partners find agreeable (Girgis, George & Anderson, 2013).

It has sometimes been suggested that the conjugal understanding of marriage is based only on religious beliefs. Although the world's major religious traditions have historically understood marriage as a union of man and woman that is by

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nature apt for procreation and childrearing. The Revisionists suggests merely that no one religion invented marriage. Instead, the demands of our common human nature have shaped (however imperfectly) all of our religious traditions to recognize this natural institution. As such, marriage is the type of social practice whose basic contours can be discerned by our common human reason and not by our religious background (Lee & George, 2008).

Marriage is a comprehensive union of two sexually complementary persons who seal (consummate or complete) their relationship by the generative act (the kind of activity that is by its nature fulfil the conception of a child). So marriage itself is oriented to and fulfilled by the bearing, rearing, and education of children. The procreative-type act distinctively seals or completes a procreative-type union. Again, this is not to say that the marriages of infertile couples are not true marriages (Lee & George, 2008).

Individuals may marry for several reasons, including legal, social, libidinal, emotional, financial, spiritual, and religious purposes. Whom they marry may be influenced by socially determined rules of incest, prescriptive marriage rules, parental choice and individual desire. In some areas of the world, arranged marriage, child marriage, polygamy, and sometimes forced marriage, may be practiced as a cultural tradition. Conversely, such practices may be outlawed and penalized in parts of the world out of concerns for women's rights and because of international law (Country Reports on Human Rights Practices, 2008). In developed parts of the world, there has been a general trend towards ensuring equal rights within marriage for women and legally recognising the marriages of

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interfaith or interracial, and same-sex couples. These trends coincide with the broader human rights movement (Country Reports on Human Rights Practices, 2008).

Marriage bestows rights and obligations on the married parties, and sometimes on relatives as well, being the sole mechanism for the creation of affinal ties (in-laws) which depends on jurisdiction of the following (Gallapher, 2002):

1. Giving a husband/wife or his/her family control over a spouse's sexual services, labour, and property.
2. Giving a husband/wife responsibility for a spouse's debts.
3. Giving a husband/wife visitation rights when his/her spouse is incarcerated or hospitalised.
4. Giving a husband/wife control over his/her spouse's affairs when the spouse is incapacitated.
5. Establishing the second legal guardian of a parent's child.
6. Establishing a joint fund of property for the benefit of children.
7. Establishing a relationship between the families of the spouses.

Marital Distress

According to Association for Advancement Behaviour Therapy (2014), approximately 50% of first marriages end in divorce, one of life's most stressful events. Even for those marriages that do not end in divorce, many are characterized by unhappiness. For example, Association for Advancement Behaviour Therapy (2014) estimated that approximately 20% of all married couples experience marital distress, or discontent with their marriages, at any given time. Despite the risk

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associated with marriage, almost 90% of the population chooses to marry at least once, and nearly 75% of divorced individuals choose to remarry. Therefore, understanding marital distress and its consequences, and developing effective marital therapy treatment programmes, has been a major focus of individuals in the field of mental health.

Marital distress has been defined as situations in which partners experience communication and problem-solving difficulties, find it difficult to work together, and have difficulty accepting each other's differences (Jacobson & Christensen, 1998). According to Holtzworth-Munroe and Jacobson (1991), distressed couples exchange fewer rewarding behaviours and more aversive behaviours than non-distressed couples, and this holds for both verbal communication and for the exchange of other forms of reinforcers. Alhassan (1997) also had the conviction that many marriages in Ghana could best be described as distressed, unhappy, and in discord, but these had not yet ended in divorce. Jacobson, Waldron, and Moore (1980) found that distressed couples are more likely than non-distressed couples to reciprocate each other's use of aversive. A study conducted by Tolorunleke (2014) on the Causes of Marital Conflicts Amongst Couples in Nigeria, also found that marital distress is the state of tension or stress between marital partners as the couple try to carry out their marital roles. Tolorunleke (2014) further stated that:

> the fact that two people agree or plan to live together as husband and wife calls for different expectations and hopes, some of which might be fulfilled while others remain unfulfilled. Since couples are humans and not gods, it is only natural to expect that there will

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be differences in opinions, values, needs, desires and habits that are the stuff of everyday living (p. 22).

This is an indication that almost every couple may have a share of marital distress which may affect the beauty of the relationship or may cause any havoc in the relationship.

Causes of Marital Distress

Although couples become unhappy with their marriages for a variety of reasons, there are several recurring themes that are frequently associated with marital distress. The most frequent problem reported by unhappy couples is poor communication. Spouses often feel that their partners are making excessive demands or requesting much more than they can give. Other spouses feel that their partners are too withdrawn or do not share or open up enough. Further, distressed spouses often avoid talking about problems in their relationships because they end up arguing and fighting with each other. These communication problems often result in spouses feeling bad about themselves, their partners, and their relationships (Gottman, Rynn, Carrere, & Erley, 2002).

A second cause of frequently marital distress is unrealistic expectations that spouses may hold about marriage or about each other. For example, spouses may believe that their partners should know what they are thinking and feeling without asking. In addition, distressed spouses are likely to have negative explanations for their partners' behaviour. For example, distressed spouses are likely to blame their partners for anything bad that occurs in the relationship (Gottman et al, 2002).

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A third problem frequently associated with marital distress is lack of intimacy or loving feelings between spouses. Although the strong emotions associated with courtship naturally decline over time in relationships, many spouses become upset when they observe such a decline. They may perceive this natural decline as a loss of love feelings, which is then often associated with a decrease in demonstrations of affection and decreased sexual activities. Other difficulties reported by distressed couples include specific problem topics, such as money management, jealousy, conflicts over values, and problems with in-laws. Other spouses become distressed when confronted with negative life events, such as the death of a family member or a serious illness. Still other couples become distressed because of changes in one person's life that leaves the partner feeling excluded. Employment success and making new friendships are common examples of this (Association for Advancement Behaviour of Therapy, 2014).

According to Anim (2013), some authors blame marital distress on factors including differences in the sexes, personality or temperaments, upbringing, and communication difficulties. Others are western education and emancipation of women, intrusion of third parties and failure to adjust (Adei, 1991). Anim (2013) further cited Mcvey (1990) who highlighted financial problems, immaturity before marriage, in-laws, accommodation problems and sexual incompatibilities as resulting in marital distress.

Marital distress is also caused by low self-esteem and lack of assertiveness as Anim (2011) opined that as self-esteem and assertiveness that is not properly developed in people, they enter marital relationships only to find out that they are

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not really mature enough to handle physical, social, emotional, mental and spiritual conflicts that erupt in marital relationships.

Anim (2011) further stressed that western education and its consequent 'emancipation' of women may have also affected marital distress in a society where male dominance is taken for granted. An educated wife may seek to exert 'equal-status' authority in the marriage, and may challenge her husband's final decisions pertaining to the home. Some highly educated couples find it difficult agreeing who controls affairs in the marriage; the husband, wife, or both? Many educated women indicated that, in marriage both should share the same authority or exercise equal-status rights and power. These ideas may make some wives behave in traditionally unacceptable ways in their relationships, and this may spark a lot of friction, communication problems, marital dissatisfaction and distress (Anim, 2011).

Rather than facing marital problems when they arise, many married couples get around it, seeking the route of least resistance. McDowell (1985) pointed out such ineffective substitutes for dealing with conflicts as failing to acknowledge the problem, withdrawal, trying to ignore the conflict's significance, spiritualising the problem with religious jargon, keeping scores, attacking the person instead of the problem, blaming someone else, desiring to win no matter the cost, giving up just to avoid conflict, and buying a special gift for the other person. All these ineffective solutions have one thing in common; they try to avoid dealing with the problem. In the end, the accumulation of unresolved conflicts take their toll with painful physical psychological, emotional, mental, and spiritual consequences, which can be termed distress in marriage.

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The gender of married couples is also a factor that is related to the emotional distress that accompanies arguments in marriage. Almeida and Kessler (1998) found that emotional distress which comes from a marital argument is more pronounced for wives than husbands suggesting that wives might be more reactive than husbands to arguments in marriage.

Effects of Marital Distress

Evidence indicates that individuals who have problems in their marriages are more likely to have a variety of psychological problems, including depression and alcoholism. Compared to individuals who are married and getting along with their spouses, both men and women who are in unhappy marriages are much more likely to be clinically depressed. In support of this, a study conducted by Guan and Han (2013) on marital distress and disease progression in China indicated that marital distress is associated with elevated blood pressure and heart rate, and depressive health symptoms particularly among women experiencing high level of distress in their marriages. Marital distress is also considered as a source of dysfunctional behaviour in marital interactions involving depressed individuals (Jackman-Cram, Dobson, & Martin, 2006). All these imply that marital distress brings untold hardships to and health complications to those affected.

Another problem reported by spouses who are having marital problems is violence within the relationship. Almost one third of all married couples will experience violence at some time in their marriage, with distressed spouses being at greater risk. Marital violence can have a major impact on the relationship and on the psychological, as well as the physical, well-being of each spouse. Amuzu (1997)

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observed that women sustain injuries as a result of marital violence which includes cuts, broken bones, concussions, miscarriages, as well as permanent injuries such as damage to joints, partial loss of hearing or vision, scars from burns, knife wounds and even death. Further, the Association for Advancement Behaviour Therapy (2014) stated that behavioural problems in children are more common in families in which the parents are unhappily married. A number of studies have found that children, who are exposed to marital distress, particularly to violence in the home, are at greater risk for their own emotional problems. This implies that children from distressed couples are likely to experience distress in their future relationships (Association for Advancement of Behaviour Therapy, 2014).

A study by Morrison, Coiro and Blumenthaf (1994) also indicated that family conflict is key among the pre-disruption factors that affect the well-being of children. Indeed, some researchers have shown that parental discord can be more disruptive to children than divorce or the loss of a father (Grych & Fincham, 1990). Children living in high conflict two-parent families manifest more social, emotional, and behavioural problems than children living in single parent families with minimal conflict. This is an indication that marriages under distress do not auger well for the well-being of children. Such children are likely to have challenges regarding their social and emotional development. Moreover, results from a study by Amato, Spencer, and Sooth (1993) also suggest that the effects of marital disruption and marital conflict that existed before divorce, often creates emotional difficulties for children, thereby making them to have adjustment problems. Marital distress actually leads to separation or divorce with its negative

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consequences. Morrison, Coiro and Blumenthaf (1994) support this assertion that, over a million children are affected by divorce each year, and there is considerable evidence that children in divorced families fare less well than their intact counter parts. Morrison and Blumenthaf, (1994) citing Schaenbotxa (1988) also documented that 14 percent of children with divorced parents needed psychological help. According to their parents, 13 percent reported that their children actually saw a psychiatrist or psychologist. This is a clear indication that children are traumatized when their parents are divorced as a result of unresolved marital distress.

Children in disrupted families also tend to score less favourably than children in two-parent families on measures of physical health and well-being (Dawson, 1991; Mauldon, 1988). Children in disrupted families also have slightly lower scores on standardised measures of academic achievement (Amato & Keith, 1991) and are rated less-favourably by their teachers than children in intact families (Guidubaldi, Perry & Cleminshaw, 1984). This implies that unresolved marital distress affects the academic performance of students. This could later affect the development of human resource of a nation.

Dawson (1991) found an increased risk of accidents, injuries and poisoning, and elevated scores for health vulnerability from divorced children in comparison to those living with both biological parents. Furthermore, the experience of parental divorce as a child is a significant predictor of the experience of difficulties in one's own marriage (Kulka &Weingarten, 1979) and of divorce (Pope & Mueller, 1979).

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Since marital disruption is not a static event, but a process that is set in motion well before the physical separation occurs, researchers are increasingly interested in the negative family processes that may exist prior to disruption and account for some of the apparent effects of divorce. In fact, a number of prospective studies have shown that some of the observed differences between children in divorced and intact families are attributable to factors that predict the disruption. For example, during the course of a 15-year study, Block and Gjerd (1986), found that, when adolescent boys from disrupted families were compared with those who remained in intact families, many exhibited behaviour problems not only after the divorce, but also some 11 years before the break-up. At ages 3, 4, and 7, boys from families that eventually got disrupted were already observed to be aggressive, incompliant, uncooperative and they tended to became anxious when their environments became unpredictable (Block et al, 1986; p. 832-3). This is an indication that children were affected during the period when their parents were having unresolved marital distress, and situations were out of hand when their parents finally got separated or divorced. This assertion was supported by Baydar (1988) when he opined that boys from disrupted families also exhibited lower psychological adjustment and greater substance abuse before the separation, but boys' difficulties increased subsequent to divorce, especially for substance abuse. These situations do not only affect boys, girls are also affected.

In a study, Doherty and Needle (1991) found that adolescent girls from disrupted families also showed greater substance abuse and lower psychological adjustment, in comparison to girls' from families that remained intact, even before

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their parents separated. This implies that both boys and girls have their share from unresolved marital challenges.

Tolorunleke (2014) also stressed that the fact that no human relationship is devoid of conflict and misunderstanding, once in a while, many families within our societies experience difficulties as a result of marital conflicts. This constitutes a major threat to sustainability of marital peace and stability in our societies; both small and large. This implies that marital distress affects not only the couples involved and their children but also, the peace and stability of society is also affected.

Managing Marital Distress

Marital success results from a lot of endurance, tolerance, patience and effective management of individual differences. Successful marriages, as opined by Nadir (2003), are not those in which there has never been conflict but those in which conflicts have served useful purposes. Hence, in order to foster marital stability and satisfaction, couples should learn to be fair, objective and realistic when dealing with their interpersonal relationships as nobody can be perfect at all times and in all things.

Managing or treating marital distress and depression appears to be efficacious when the couples resort to behavioural marital therapy (Beach, 2001). However, before discussing behavioural marital therapy for depression (BMT-D), it is necessary to review other treatments that have been found to be effective. The empirically supported treatments for depression and co-occurring marital distress include psychopharmacological mediation, interpersonal psychotherapy,

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emotionally focused therapy, cognitive behavioural therapy and behavioural marital therapy.

Psychopharmacological treatment

Treatment of individual suffering from depression using antidepressant medications appears to be on the rise. Olfson, Marcus and Weissman (2002), using the Medical Expenditure Panel survey from 1987 to 1997 determined that in the U.S., the use of antidepressant medications have increased markedly, and psychotherapy sessions have become less common. Undoubtedly, the use of medications have increased among physicians but Olfson et al.'s (2002) report on the reduction in psychotherapy sessions might be questioned based on their sampling procedures. While physicians struggle to find the best medications or combinations of medications to depression, others report that medication is only part of the treatment (Ferrier, 2001). Many see the need for psychotherapy as an adjunct to medication (de la Fuente, 2001), or as a sequential treatment needed because treatment by pharmacotherapy appears to leave substantial amount of residual symptoms (Fava, 1999).

Pharmacological treatment has been found to be as effective as amrita therapies in treating marital distress (Friedman, 2010; Teichman, Bar-El, & Elizur, 1998). In a study by Bellack, Hersen and Himmethock (1980), pharmacotherapy was shown to improve only depression, whereas if patients were treated with psychotherapy, social skills and depression improved. In contrast Zeiss, Lewinsohn, and Munoz (1979) found that interpersonal skills training, pleasant activities schedule, or cognitive training treatments did not help specific

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interpersonal skills targets, but all three changes interpersonal symptoms. Several studies, in contrast, suggest that improving the marriage may reduce depressive symptoms (Beach & O'Leary, 1992; Teichman, Bar-el, Shor & Elizur 1998). Therefore, when treating marital distress and co-occurring depression, it appears that medication may be needed for major depression when symptoms are debilitating but the treatment should be augmented with marital therapy to work towards remission of both depression and marital distress.

Interpersonal psychotherapy

Foley, Rounsaville, Weissam, Sholomaskas, and Chevron (1989) compared the effects of Interpersonal Psychotherapy using two different formats. These are individual interpersonal psychotherapy and conjoint marital interpersonal therapy. Both groups of patients were found to have reduced depressive symptoms and increased social skills. However, the conjoint marital therapy group was found to have better marital adjustment than the individual therapy group. It is interesting that partners of the depressed spouse were found to have better marital adjustment, regardless of which interpersonal psychotherapy format was used (Beach, 2001).

Emotionally Focused Therapy

Emotionally focused therapy (EFT) has been shown to be efficacious for marital distress (Johnson & Greenberg, 1995). Further, EFT has been reported to be helpful in the treatment of marital distress and depression (Johnson & Williams-Keeler, 1998). Dessaulles (1991) compared pharmacotherapy and EFT in a sample of marital distressed couples in which the wife was depressed. It appears that EFT had an impact on wives' depression more than marital adjustment. At this time,

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EFT appears to be only somewhat efficacious for marital distress and co-occurring depression.

Cognitive Therapy

Rush, Shaw, and Khatami (1980), using a case study method, found that cognitive therapy is useful with couples with a depressed spouse. Teichman et al. (1995, 1998) have studied the efficacy of cognitive marital therapy as a treatment for depression. In the 1995 pre-post treatment study, they found that cognitive marital therapy (CMT) outperformed individual cognitive therapy (CT) as a treatment of depression, and that both the depressed patients and their spouses had reduced symptoms of depression. Cognitive marital therapy outcomes were superior to a wait-list control group. In the 1998 study, they compared CMT, CT, pharmacotherapy, and a wait-list control group. Pre and post-treatment and pre-treatment to follow-up changes were compared. The CMT patients' were found to have improved in their cognitions and emotions but not in their behaviours. The pharmacological treatment was superior on its effects on patients' emotions whereas CT affected patients' cognitions but not the other variables (Kung, 2000). As noted by Cordova and Gee (2001), although the Teichman 1998 studies found marital therapy to be an effective treatment for depression, they did not include a measure of marital satisfaction. Therefore, they did not address CMT as an effective treatment for both depression and marital distress.

Behavioural Marital Therapy

Behavioural Marital Therapy (BMT) have been found to be efficacious for treating marital distress (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Bray

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& Jouriles, 1995), both in United States and in other cultural settings including Belgium, Germany, Great Britain, and Netherlands (Hahlweg & Markman, 1988). Behavioural Marital Therapy has also been found to be an effective treatment for co-occurring marital distress and depression (Beach, 2001; Cordova & Gee, 2001). Beach (2001) states that BMT-D "is a safe and effective intervention with proven efficacy in relieving marital discord" (p. 209) and it appears "to enhance marital functioning and relieves depressive symptoms" (p. 209). Behavioural marital therapy for depression begins with assessment and diagnosis for specification of the problem. If one or both spouses are found to be depressed then behavioural marital therapy is applied with a direct focus on the depressive behaviours.

Marital Distress and Gender

Gender roles influence differences in the ways in which men and women manage distress. According to Gottman (1999), women are more likely to initiate discussions of conflictual relationship issues. Men have been found to be more likely to withdraw from negative marital interactions, while women are more likely to pursue the conversation or conflict (Johnson, 1996). Women are more prone than men to experience depressive episodes in marriages. In another study, Obodia (2012) found a statistical significant difference between male and female married people in terms of marital distress. He added that the females were more distressed in their marriage than males, in a study he conducted in the Ajumako District of the Central region. This distinction might be based on biological and hormonal differences, particularly concerning the prevalence of Major Depressive Disorder (MDD) (Kessler, 2003; Kennedy, Einstein & Downar, 2013).

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Women also report higher depressive symptoms levels, suggesting a difference between genders in expressing depressive symptomatology (Molina et. al., 2014).

The gender of married couples is a factor that is related to the emotional distress that accompanies arguments in marriage. Almeida and Kessler (1998) found that emotional distress which comes from a marital argument is more pronounced for wives than husbands suggesting that wives might be more reactive than husbands to arguments in marriage. Studies consistently find gender differences in certain measures of health, such as anxiety, depression, and some physical illnesses (Weissman & Klerman, 1977; Nolen-Hoeksema, 1987; Cleary, 1987; Barnett, Biener & Baruch, 1987; Mirowsky & Ross, 1995). Although the literature examining the relation between gender and stress reveals several conflicting outcomes, numerous authors have determined that women find themselves in stressful circumstances more often than men (Almeida & Kessler, 1998; McDonough & Walters, 2001).

Other authors have suggested that it is possible that women appraise threatening events as more stressful than men do (Miller & Kirsch, 1987; Ptacek, Smith, & Zanas, 1992). Furthermore, women have been found to have more chronic stress than men (McDonough & Walters, 2001; Turner et al., 1995; Nolen-Hoeksema, Larson, & Grayson, 1999) and are exposed to more daily stress associated with their routine role functioning (Kessler & McLeod, 1984). Women are also more likely to report home and family life events as stressful (Oman &King, 2000) and stress related to gender caring roles (Walters, 1993). In addition, women experience gender-specific stressors such as gender violence and sexist

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discrimination, which are associated with women's physical and psychiatric events (Heim et al., 2000; Klonoff, Landrine, & Campbell, 2000; Koss, Koss, & Woodruff, 1991). Women were also more affected by the stress of those around them, as they tend to be more emotionally involved than men in social and family networks (Kessler & McLeod, 1984; Turner et al, 1995).

In their studies, Ball, Cowan, and Cowan (1995) examined gender differences during marital problem solving discussions. They transcribed audio taped accounts of couples working on solving a problem concerning division of family labour and self-report questionnaires of 27 couples were examined. The findings of the study revealed that women tended to raise the issues and draw men out in the early phase of the discussion, while men controlled the content and emotional depth of the later discussion phases, and largely determined the outcome. Again, many studies have found that wives' reports of marital satisfaction are significantly lower than husbands' (Kamp-Dush, Taylor, & Kroeger, 2008; Stevenson, & Wolfers, 2009; Whiteman, McHale, & Crouter, 2007). For example, national surveys of married adults in the United States in 1980 and 2000 found that, on average, women reported lower levels of marital quality (Amato, Booth, Johnson, & Rogers, 2007). Other studies, though, have found no gender differences (Kurdek, 2005). For instance, using national probability data from the National Study of Families and Households, Gager and Sanchez (2003) found no significant differences in the mean levels of husbands' and wives' marital satisfaction.

According to Waite (1995), men benefit more than women from marriage, with husbands having significantly better health than wives. In support of her

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argument, there is empirical evidence that men derive more health benefits than women from being married. A nationally representative longitudinal study found that the transition to first marriage for men was associated with a 27.9% increase in the probability of being in excellent or very good health, compared to a 4.8% increase for women (Williams & Umberson, 2004). Likewise, men's transition to remarriage was associated with a greater health benefit than for women. Men also benefit more than women from marriage because women shoulder the majority of child care and housework (Bernard, 1972). Indeed, the inequitable division of household labour and child care has been a central focus of feminist theory and research (Ferree, 2010; Osmond & Thorne, 1993).

Since the Industrial Revolution, which moved husbands from working on family farms and businesses with their wives to working at factories and outside businesses, women have had primary responsibility of household duties. Although research suggests that husbands' level of participation in household tasks has increased (Sayer, 2005), wives still perform a disproportionate amount of household tasks (Baxter, 2002) and child care (Bianchi & Milkie, 2010). Evidence suggests that husbands resist their wives' efforts to more equally distribute child care and housework and that wives are generally unhappy with the division of labour in their relationships (Dempsey, 2000). This lack of equitable division of labour is associated with lower marital satisfaction which eventually leads to marital distress (Grote & Clarke, 2001; Stevens, Kiger, & Mannon, 2005).

It is also important to emphasise that CBT has been known as one of the prominent therapies used for psychological disorders and conflicts between couples

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(Poulsen et al., 2014). This is done by creating positive mental states and factors. CBT can play a key role in protecting couples from various diseases and their side effects, immunizing them and preventing these kind of negative states. Numerous studies have focused on the effectiveness of CBT. One of them was the research conducted by Pines and Nunes (2003), showed that CBT affects the satisfaction of pregnant women. Boostanipoor, Sanayi-Zaker, and Kiamanes (2007), in their research called a meta-analysis of the effectiveness of cognitive behavioural patterns in the treatment of marital problems, came to the conclusion that 17% of women treated by cognitive behavioural marital therapy have shown more improvement. Hafezi-Kan and Ghadami (2011) concluded that CBT affects the level of marital satisfaction. The research conducted by Cho et al. (2008) showed that CBT is effective when it comes to reducing automatic negative thoughts, dissatisfaction with mutual relationships and overall marital dissatisfaction.

Marital Distress and Age

According to Bradbury, Fincham and Beach (2000), many marriages go through turbulent times that cause great distress for couples. These put couples at risk for developing higher levels of depression and anxiety. Demographic characteristics such as age has been linked to marital satisfaction and marital conflict (Knox & Schacht, 2000). Individuals who marry when they are at least into their '20's are predicted to have greater marital satisfaction and marital stability (Tzeng, 1992). In particular, teenage marriages are more vulnerable to divorce, as these unions are typically associated with premarital pregnancy, lower education and income, less social support, and individuals choosing marriage at an early age

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may also exhibit interpersonal characteristics which place marital stability in danger such as poor decision making (Stanley & Markman, 1997).

Most research in the area of marital satisfaction has focused on age at the time of marriage (Booth & Edwards, 1985). There is virtually unanimous agreement that there is an inverse association between the age at first marriage and the probability of divorce, meaning that the younger one when married, has a higher risk of divorce (Lee, 1977). People who marry early are at a higher risk of marital instability than those who marry later in life. One major reason for addressing age is that factors which are negatively related to marital "success" (i.e. whether one divorces or remains married) include many which are related to age at time of marriage, such as low education, premarital pregnancy, short premarital acquaintance, personality maladjustment, and low socioeconomic background.

Bramlett and Mosher's (2001) research finding was contained in a report in the USA released by the National Centre for Health Statistics that one fifth of first marriages ended within 5 years and one third ended within 10 years. First marriages of teenagers disrupted faster than the first marriages of women who were ages 20 years and older at marriage. The same report estimated that approximately 50% of first marriages end in divorce, one of life's most stressful events; that for those marriages that do not end in divorce, many are unhappy. It has been estimated that at any given time, approximately 20% of all married couples go through marital distress. In particular, spouses who differ in age, rage, education, and religion may be more vulnerable to marital conflict and marital dissatisfaction (Houts, 1996).

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Furthermore, Bumpass and Sweet (1972) studied whether the inverse correlation between age at time of marriage and marital instability was attributable to the participant's education, premarital pregnancy, religious affiliation, parental marital stability, or husband's marital history. They performed a multivariate analysis on a large sample of married, white women under the age of 45, and found that marital instability was not attributable to the aforementioned factors. Their data showed that age at marriage was the strongest single predictor of marital instability in their analysis. This means that, absent of all other seemingly relevant variables, age at time of marriage was the strongest predictor of marital stability.

Also, Lee (1977) studied the relationship between marital satisfaction, age at marriage, and marital role performance. This study used data from a non-random sample of 394 married couples, including spouses' evaluations of role performance in order to gain a more accurate response. All respondents were in their first marriage, had been married six years or less at the time of the study, and were under 35 years of age. Through the use of multivariate analysis, Lee found a positive correlation between age at the time of marriage and marital satisfaction after controlling for the antecedent variables of length of marriage, education, socioeconomic background, and religious importance. This means that as the age at marriage increased, marital satisfaction increased as well. This positive correlation finding was true for both males and females. Lee concluded, however, that the strength of the correlation was moderate at best, and may be related to an unmeasured third variable – potential for remarriage. He hypothesized that those

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who marry young may be cognizant of their better potential to remarry in the event of a divorce, and may then be less willing to tolerate dissatisfaction.

Jose and Alfons (2007) also examined the effects of age, number of children, employment status, and length of marriage on marital satisfaction. They found that those who married later were more likely to remain married, but those who married younger and get divorced are more likely to remarry. Contrary to previously stated results, these researchers found that age had a significant negative effect on the sexual adjustment and marital adjustment of first-married adults. In other words, the older one was at the time of first marriage, the less adjusted individual and consequently, the less satisfied. Middle-aged adults seemed to have greater adjustment problems than both young and elderly participants involved in the study.

However, Peters (2014) found in Lusaka, Zambia that marital satisfaction of disenchanted couples revealed no significant difference in age of couples. Peters explained that premarital counselling in his view might have compensated the younger couples and build up with experience as the older generation have. Similarly, Dabone (2012) also found no significant difference between young and old married people in terms of marital satisfaction. Even though his findings revealed that older married people were more satisfied in their marriages than younger married people, the difference was not significant.

Marital Distress and Length of Years in Marriage

Length of marriage has been studied infrequently in relation to marital distress, and sources of information are much less prevalent than the previous

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variables of gender and age. According to Gottman (1999), length of marriage is also a significant predictor for marital satisfaction and marital distress. He identifies two critical time periods of vulnerability in the marital trajectory, with the majority of couples divorcing within the first seven years of marriage. Couples' who divorce within the first seven years of marriage have relationships characterized by having high levels of marital distress. Conversely, a second vulnerable time period for the marital trajectory is 16 to 24 years of marriage. This is the next most likely time frame for couples to divorce. These relationships are characterized by spending little time together, lack of communication, and a lack of conflict expression.

A study conducted by Kamp-Dush, Taylor, and Kroeger (2008) used longitudinal data (N = 1,998) to test for the course of marital happiness over time. Respondents were surveyed in six different waves that spanned 20 years (1980-2000). The researchers found that, though the respondents reported varying levels of overall happiness (separated into "low," "middle," and "high" happiness groups), all groups experienced a decline in marital happiness over time. They concluded that, over time, people become increasingly less satisfied with their relationships, though this lack of satisfaction is mediated by the respondents' original happiness in their marriages. In other words, people who were originally in the "high" happiness group experienced less of a decline than those in the "low" happiness group, though everyone experienced a decline.

However, Nyameye (2015) found no significant difference in the marital quality of spouses in terms of the length of marriage. In a similar study, Atitola (2013) found out that the length of time in marriage was the least predictor for

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marital success. Out of the 15 predictors of marital success, the length of time in marriage placed 15th. He was of the opinion that, finances, temperament, in-law influences were the most contributing factors to marital distress.

The Role of Counselling in Reducing Marital Distress

The concept of guidance and counselling as helping relationships, according to Maisamari (2005), is complex and multi-dimensional, covering various aspects of human development and endeavour, including marriage. Marriage counselling is a helping service. Uwe and Obot (2000) also see it as a specialized help given to partners in marriage to enable them settle their differences and work together to achieve the objectives for which they entered the union. The role of marital counselling, in helping couples to overcome marital conflicts cannot be over emphasised. Counselling in our present day generation is useful to all persons and at every stage of life. A counselling psychologist, who will therefore work with couples that are experiencing marital conflicts, needs to develop certain intervention strategies which will help couples to understand themselves, the threat to their union and take decisions that will help them to resolve their differences. To do this effectively, modern marriage counselling psychologists need to be adequately grounded in the theories and practices guiding the profession. This is due to the fact that counselling as an interactive process is characterized by a unique relationship between the counsellor and the client, which is expected to lead to a change in the client's behaviour. There are also different counselling theories at the disposal of the counsellor to help couples in resolving their marital conflicts through preventive and remedial roles of counselling. When couples come to the

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reality that whatever they disclose to the counsellor as regard their on-going marital conflicts will be kept in ultimate confidence, they will open up and the marriage counsellor will be able to guide the couple in order to arrest any problematic situation.

THEORETICAL REVIEW

Becker's Economic Theories

The Noble committee singled out Becker's economic theories of family as a major contribution when it awarded him with a prize in 1992. Economic models of marriage occupy a central place in Becker's theory of the family. Economic analysis has been applied to marriage since Becker's seminal articles in 1973 and 1974. These economic analyses assume that marriages are like firms, they are mostly non-commercial and they nevertheless produce valuable goods. Marriage here is used in a broad sense and includes partnerships similar to marriage. From the onset, Becker (1973) presented two theoretical models of marriage: a Demand and Supply (D&S) model assuming homogeneous participants competing with each other, and an Optimal Sorting Model assuming a rank ordering of heterogeneous participants.

The Structural-Functional Theory

Structural functionalism, or simply functionalism, is a framework for building theory that sees society as a complex system whose parts work together to promote solidarity and stability (Bernard, 1972). This approach looks at society through a macro-level orientation, which is a broad focus on the social structures that shape society as a whole, and believes that society has evolved like organisms (Bernard,

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1972). This approach looks at both social structure and social functions. Functionalism addresses society as a whole in terms of the function of its constituent elements; namely norms, customs, traditions, and institutions. A common analogy, popularized by Herbert Spencer, presents these parts of society as "organs" that work toward the proper functioning of the "body" as a whole (Barns, 1971).

The Structural-Functional theory also studies groups of people or organisations in society, and looks for the events or other things that hold that group together. The question that fits this theory is, "What are the consequences of marriage for the operation of society?" By looking at the consequences of marriage, Structural-Functionalists are looking at the most significant functions that hold a marriage together and make it work. There are many functions that hold together a marriage, but Structural-Functionalists study marriage from a macro or broad perspective. This lets them focus not on the less common functions that affect some marriages, but on the biggest, most important functions that affect nearly every marriage (Durrell, 2008).

Social-Conflict Theory

The Social-Conflict theory studies the differences in people, and the disputes and problems that are caused by this. Conflict theorists also study from a macro or broad perspective looking at the major trends of different ethnic groups' roles and acceptance in society. The question that fits this theory is, "How does marriage benefit women and men unequally?" When this theory is applied, men are viewed as being superior to women. This creates conflict because the men are trying

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to maintain their power and women are attempting to seize more power. By studying the benefits that men and women receive from marriage, they are actually comparing men and women. They can then see the major conflicts this causes in a marriage (Durrell, 2008).

Symbolic-Interaction Approach

The Symbolic-Interaction approach looks at a situation from the point of view of an individual that is in the situation, and what the individuals think and how they communicate based on the society they live in. The question that fits this theory is, "What do people think marriage means?" They view the setting from a micro or close-up perspective. They view each setting or situation from the inside out, by studying the people that are in the situation and finding out how differences in society make people think differently about the situation. They also study how people act in a situation and the symbols or language they use according to how they have been taught by the society they live in (Durrell, 2008). Each theory plays a different part in understanding the society we live in. When we look at a structure such as marriage using all three theories we can see the complete picture from every angle. This lets us understand a structure or group of people much better than if we just look at it from our own limited perspective (Durrell, 2008).

Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy (CBT), developed by American psychiatrist Aaron T. Beck, is a therapeutic approach that is used to deal with problems relating to cognitive behaviour. It is an insight focused therapy that emphasizes on changing negative thoughts and maladaptive behaviours. Cognitive behaviour therapy

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(CBT), originally known as cognitive therapy (CT) combines both cognitive and behavioural principles and methods in a short-term treatment approach (Beck 1963, 1967). Beck's observations of depressed clients revealed that they had a negative bias in their interpretation of certain life events, which contributed to their cognitive distortions (Dattilio, 2006). In CBT, reality testing is highly organised where clients come to realise an experiential level, that, they have misconstrued their situations. CBT places more emphasis on helping clients discover and identify their misconceptions. In CBT the therapist attempts to collaborate with client in testing the validity of clients' cognitions. Beck observed that, often, these automatic thoughts that patients were unaware of were followed by unpleasant feelings that they were very much aware of (Beck, 1991).

According to Antony and Watling (2006), Cognitive-Behavioural Therapy is a psychological treatment that was developed through scientific research. That is, all the components of CBT have been tested by researchers to determine whether they are effective to do what they are intended to do. Research has shown that CBT is one of the most effective treatments for the management of anxiety. This could be done with a trained therapist, or the client can apply CBT principles at home to manage their own anxiety and conquer their fears. CBT involves learning new skills to manage ones' symptoms. It teaches people new ways of thinking and behaving that can help them to get control over their anxiety in the long-run.

The British Association for Behaviour and Cognitive Psychotherapies (2005) also stated that Cognitive Behaviour Therapy (CBT) is a talking therapy that can help people who are experiencing a wide range of mental health difficulties.

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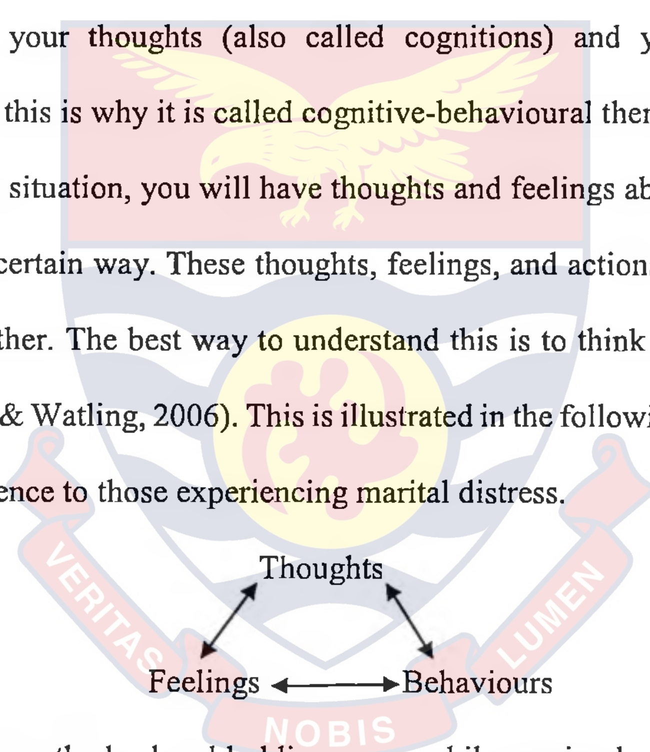
How people think can affect how they feel and how they behave, and this is the basis of CBT. During times of mental distress, people think differently about themselves and what happens to them. Negative thoughts can become extreme and unhelpful. This can worsen how a person feels. People therefore behave in ways that prolongs their distress. CBT practitioners help people to identify and change their extreme thinking and unhelpful behaviour. In doing this, the result is often a major improvement in how a person feels and lives. CBT also involves learning how to change your thoughts (also called cognitions) and your actions (or behaviours), and this is why it is called cognitive-behavioural therapy.

In any given situation, you will have thoughts and feelings about the situation and behave in a certain way. These thoughts, feelings, and actions all interact and influence each other. The best way to understand this is to think about them as a triangle (Antony & Watling, 2006). This is illustrated in the following diagram with a particular reference to those experiencing marital distress.



A wife saw the husband holding a gun while coming home. The woman may become afraid, thinking the husband will shoot her and run away from the house. In our triangle, it would look like this;

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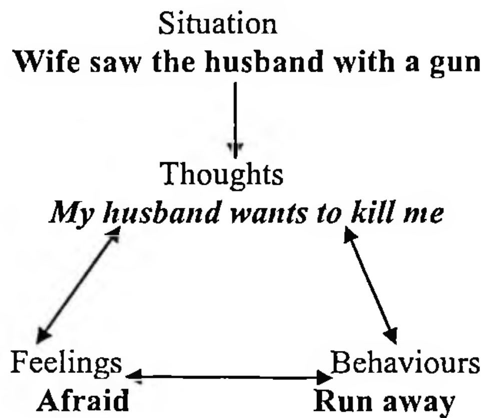

However, if the woman saw the gun and imagines that the husband has bought her a gun for her to protect herself against robbers, she will become happy and collect the gun and thank the husband. Her thought, feelings, and actions might be very different. In our triangle, it would look like this;

The examples above imply that when our thoughts are negative, it will affect our feelings and our behaviour to become negative. But when we change our thoughts by having a positive view of issues and situations, then our feelings and behaviours tend to become positive. It is generally believed that many people are suffering from marital distress because they mostly read negative meaning into their marital issues.

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In further support of this, Beck (2011) proposes that dysfunctional thinking, which influences the patient's mood and behaviour, is common to all psychological disturbances. When people learn to evaluate their thought in a more realistic and adaptive way, they experience improvement in their emotional state and in their behaviour. Therefore, for lasting improvement in clients' mood and behaviour, cognitive therapists work at a deeper level of cognition: patients' basic beliefs about themselves, their world, and other people. According to Beck (2011), individuals ignore much positive information relevant to them and rather focus on negative information about themselves. In doing so, patients may distort observations of events by exaggerating negative aspects, looking at things as all black or all white. Comments such as "I never can do anything right," "Life will never treat me well," and "I am hopeless" are common with such people. Many of these thoughts developed into beliefs about worthlessness, being unlovable, and so forth. Such beliefs, Beck (1967) hypothesized, were formed at earlier stages in life and became significant cognitive schemas. For example, a wife without children, two years after getting married may say to herself, "I'm barren, I can't take seed, my husband will divorce me because of this, he will no longer love me, he will soon change, he will marry another woman" Such an expression is a verbalization of a cognitive schema indicating a lack of self-worth. This can put this woman in a stressful situation.

Vivyan (2009) also opined that Cognitive Behaviour Therapy is a form of psychotherapy that talks about two major issues. Firstly, how you think about yourself, the world and other people, and secondly, how what you do, affect your thoughts and feelings. CBT helps people to change how they think ("Cognitive")

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and what they do ("Behaviour"). These changes can help people to feel better. Unlike some of the other talking treatments, CBT focuses on the "here and now" problems and difficulties. Whilst it is often useful to discuss the past and understand how our pasts have influenced our lives and how problems have arisen, CBT mostly focuses on looking for ways to improve your mental wellbeing now. Vivyan further opined that it is not events that cause our emotions, but how we interpret that event, how we think, or the meaning we give to events or situations that produces the emotions.

In further support of this, Hatloy (2012) also assert that CBT is a form of talking therapy that combines cognitive therapy and behaviour therapy. It focuses on how you think about the things going on in your life – your thoughts, images, beliefs and attitudes (your cognitive processes) – and how this impact on the way you behave and deal with emotional problems. It then looks at how you can change any negative patterns of thinking or behaviour that may be causing you difficulties. In turn, this can change the way you feel.

Philosophical Underpinnings of the Theory (Basic Assumptions)

CBT has the following basic Assumptions

1. CBT assumes that, to understand the nature of an emotional episode or disturbance, it is essential to focus on the cognitive content of an individual's reaction to the upsetting event or stream of thoughts (Derubeis & Beck, 1988).

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2. People's internal communication is accessible to introspection. The goal is to change the way clients think by using their automatic thoughts to reach the core schemata and begin to introduce the idea of schema restructuring.
3. Clients' beliefs have highly personal meanings, and these meanings can be discovered by the client rather than being taught or interpreted by the therapist (Weishaar, 1993).
4. The way people feel and behave is determined by how they perceive and structure their experiences.
5. The most direct way to change dysfunctional emotions and behaviours is to modify inaccurate and dysfunctional thinking. This is done by encouraging clients to gather and weigh the evidence in support of their beliefs.
6. Emotion is a by-product of cognition and behaviour and is addressed in a different fashion of particular interest in understanding.
7. Psychological disorders are cognitive distortions, inaccurate ways of thinking that contribute to unhappiness in life. CBT believes that distressing emotions are typically the result of maladaptive thoughts
8. The problems with people and the way to fix them are located inside the individual's head, rather than out in culture and in the world (Prochaska and Norcross, 1994).

Major Concepts and Principles of CBT

Beck (2003) contends that people with emotional difficulties tend to commit characteristic "logical errors" that tilt objective reality in the direction of self-depreciation. Here are some of the systematic errors in reasoning that lead to faulty

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assumptions and misconceptions, which Beck termed as Cognitive Distortions (Beck & Weishaar, 2008; Dattilio & Freeman, 1992).

i. **Arbitrary inferences/ Catastrophizing**

This refers to the situations where individuals take an event about themselves and exaggerate it to look fearful. By this, they make conclusions without supporting or relevant evidence. For instance, you may be married but you feel your spouse might not like you.

ii. **Selective abstraction**

This is the act of drawing conclusions based on isolated details of an event. All other information is ignored, and the significance of the total context is missed. The assumption is that the events that matter are those dealing with failure and deprivation. Here, the individual measures his or her worth by his or her errors and weaknesses, not by his or her successes.

iii. **Overgeneralization**

This is a process of holding extreme beliefs on the basis of a single incident and applying them inappropriately to dissimilar events or settings. For example, your husband once remarked that your food is not delicious. You might therefore conclude that your husband is no more interested in whatever you do.

iv. **Magnification and minimization**

This is the process of perceiving an event in a greater or lesser light than it truly deserves. For instance, magnifying imperfections or trivial issues and minimizing perfections or good points.

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v. **Personalization**

This is a tendency for individuals to relate external events to themselves, even when there is no basis for making such connections. If your spouse does not return home early after a short disagreement you might be absolutely convinced that this late return is due to the short disagreement and your spouse just want to avoid you thereby relating unrelated events to yourself.

vi. **Labelling and mislabelling**

This is where people have negative view of themselves based on some errors committed in the past. For example, portraying one's identity on the basis of imperfections and mistakes made in the past and allowing them to define one's true identity. Thus, if you are not able to live up to your spouse expectations, you might say to yourself, I may not be the right person.

vii. **Dichotomous thinking**

This is also known as all-or-nothing thinking, which involves categorizing experiences in either-or extremes. With such polarized thinking, events are labelled in black or white terms.

viii. **Mind reading**

This refers to the idea that we know what another person thinks about us. For instance a man may conclude that his wife no longer loves him that's why she refuses to go out shopping with him. In fact the wife may have many tangible reasons for not going out with him.

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ix. Negative prediction

This is the belief that something bad will be happening meanwhile there is no evidence to support it. Such a belief may create stress, tension and anxiety in the person.

Cognitive Behavioural therapy perceives psychological problems as stemming from commonplace processes such as faulty thinking, making incorrect inferences on the basis of inadequate or incorrect information, and failing to distinguish between fantasy and reality. Beck (2011) contends that people with emotional difficulties tend to commit characteristic "logical errors" that tilt objective reality in the direction of self-depreciation. Cognitive therapists view dysfunctional beliefs as being problematic because they interfere with normal cognitive processing, not because they are irrational (Beck & Weishaar, 2008). Instead of irrational beliefs, Beck (2011) maintains that some ideas are too absolute, broad, and extreme. For him, people live by rules, premises or formulas, and get into trouble when they label, interpret, and evaluate, by a set of rules that are unrealistic or when they use the rules inappropriately or excessively. This often creates problems for them leading to distress in their relationships.

As stipulated by Beck (2003), psychological distress can be caused by a combination of biological, environmental, and social factors, interacting in a variety of ways, so that there is rarely a single cause for a disorder. Beck prefers to use the term "rules" to irrational beliefs. He identifies six of such rules as:

1. In order to be happy, I have to be successful in whatever I undertake
2. To be happy, I must be accepted by all people at all times

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3. If I make a mistake, it means that I am inept
4. I can't live without love
5. If somebody disagrees with me, it means he doesn't like me
6. My values as a person depends on what others think of me (Rimm & Masters, 1979)

A person behaving abnormally may possess cognitive distortion and systematic biases (cognitive shift) in processing information. Psychological distress is all about cognitive distortions also known as depresogenic assumptions. For instance, a middle aged woman whose marriage collapsed, may resort to internal conversations (depresogenic assumptions) like "*I will never be able to marry again, what else is there to my life?' 'It's all hopeless, nothing left in life.*"

Mode of practice of CBT (Therapeutic relationship between client and Counsellor)

The CBT is an active therapy in which the therapist collaborates with the client in here and now. It uses verbal therapy, and each session establishes an agenda, structures and therapy time. It summarises periodically what is happening, questions the client, assigns homework and asks the client to sum up the session. Beck (2003) emphasizes the necessity of accurate empathy, warmth and genuineness in the helping relationship. To Beck (2003), rapport, collaboration and mutual understanding are important in therapy. The cognitive therapist teaches clients how to identify distorted and dysfunctional cognitions through a process of evaluation. The therapist who is largely a teacher is able to combine empathy and sensitivity, along with technical competence. The core therapeutic conditions

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described by Rogers in his person-centered approach are viewed by cognitive therapists as being necessary, but not sufficient, to produce optimum therapeutic effect (Beck, 1987).

Cognitive therapists are continuously active and deliberately interactive with clients, helping clients frame their conclusions in the form of testable hypotheses. Therapists engage clients' active participation and collaboration throughout all phases of therapy, including deciding how often to meet, how long therapy should last, and what problems to explore (Beck & Butler, 2005).

The frequently asked question is, "Where is the evidence for .....?" This practice usually includes assessment with standardized instruments and techniques, Socratic dialogue, decastastrophising, decentring and refining. The past may be brought into therapy when the therapist considers it essential to understand how and when certain core dysfunctional beliefs originated and how these ideas have a current impact on the client's specific schema (Dattilio, 2002).

The goals of CBT include providing symptom relief, assisting clients in resolving their most pressing problems, and teaching clients relapse prevention strategies. Another goal is to change the way clients think by using automatic beliefs to reach the core schemata and begin to introduce the idea of schema restructuring. Cognitive therapists aim to teach clients how to be their own therapist. Typically, a therapist will educate clients about the nature and cause of their problem, the process of cognitive therapy, and how thoughts influence their emotions and behaviours. One way of educating clients is through bibliotherapy, in which clients complete readings dealing with the philosophy of cognitive therapy.

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According to Dattilio and Freeman (1992, 2007), these readings are assigned as an adjunct to therapy and are designed to enhance the therapeutic process by providing an educational focus. Emphasis is placed on self-help assignments that serve as a continuation of issues addressed in a therapy session (Dattilio, 2002). Cognitive therapists realize that clients are more likely to complete homework if it is tailored to their needs, if they participate in designing the homework, if they begin the homework in the therapy session, and if they talk about potential problems in implementing the homework (Beck & Butler, 2005). The three major stages of therapeutic relationship in CBT are:

1. Eliciting thoughts, self-talk, and the clients interpretation of these thoughts
2. Gathering with the client evidence for or against the client's interpretation
3. Setting up experiments (homework) to test the validity of the clients' interpretations and to gather more data for discussion.

All these imply that therapists focus more on helping clients become aware of their self-talk. Together, the therapist and client practice the self-instructions and the desirable behaviours in role-play situations that simulate problem situations in the client's daily life. The emphasis is on acquiring practical coping skills for problematic situations such as impulsive and aggressive behaviour, fear of taking tests, and fear of public speaking.

The Process of CBT

CBT uses several techniques in the process of therapy. Meichenbaum (1977) describes a three-phase process of change that is interwoven in themselves. According to him, focusing on only one aspect will probably prove insufficient.

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Phase 1: Self-observation: In the first phase, clients are assisted to learn how to observe their own behaviour. This process involves an increased sensitivity to their thoughts, feelings, actions, physiological reactions, and ways of reacting to others. Clients are made aware that they are not victims but rather, they are actually contributing to their depression through the things they tell themselves. As therapy progresses, clients acquire new cognitive structures that enable them to view their problems in a new light. This reconceptualisation process comes about through a collaborative effort between client and therapist.

Phase 2: Starting a new internal dialogue: As a result of the early client–therapist contacts, clients learn to notice their maladaptive behaviours, and they begin to see opportunities for adaptive behavioural alternatives. Clients' new internal dialogue serves as a guide to new behaviour.

Phase 3: Learning new skills: The third phase of the modification process consists of teaching clients more effective coping skills, which are practiced in real-life situations. As they behave differently in situations, they typically get different reactions from others. Meichenbaum (1977) uses these questions to evaluate the outcomes of therapy:

1. Are clients now able to tell a new story about themselves and the world?
2. Do clients now use more positive metaphors to describe themselves?
3. Are clients able to predict high-risk situations and employ coping skills in dealing with emerging problems?
4. Are clients able to take credit for the changes they have been able to bring about?

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In successful therapy, clients develop their own voices; take pride in what they have accomplished, and take ownership of the changes they are bringing about. Although cognitive therapy often begins by recognising the client's frame of reference, the therapist continues to ask for evidence for client's belief system. Tsapelas, Aron, and Orbuch, (2009) point out that there are clear advantages to the therapist and the client working in a collaborative manner in negotiating mutually agreeable homework tasks. He believes that one of the best indicators of a working alliance is whether homework is done and done well.

The Counsellor's role in CBT: The counsellor is expected to carry out the following functions during the therapeutic relationship:

1. The therapist functions as a catalyst and a guide who helps clients to understand how their beliefs and attitudes influence the way they feel and act.
2. Wolfe (2007) suggests that the CBT therapist's job is to help clients examine and challenge long-standing cultural assumptions, only if they result in dysfunctional emotions or behaviours.
3. Therapist should also assists clients in critically thinking about potential conflicts with the values of the dominant culture so they can work toward achieving their own personal goals within their own sociocultural context.
4. The therapist provides graded task assignments. For instance a housewife who sees herself as a total failure might be asked initially to do nothing than to boil an egg, and continue from there.

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5. The therapist helps client to appreciate how they construct their realities and how they author their own stories.

Client's role in Cognitive Behavioural Therapy

Clients are also expected to carry out the following functions:

1. Clients are expected to identify the distortions in their thinking, summarize important points in the session, and collaboratively devise homework assignments that they agree to carry out (Beck, 2003; Beck & Butler, 2005; Beck & Weishaar, 2008).
2. Clients are to engage in self-discovery. The assumption is that lasting changes in the client's thinking and behaviour will be most likely to occur with the client's initiative, understanding, awareness, and effort.
3. Clients should learn to engage in more realistic thinking whenever they get caught up in catastrophic or negative thinking.

Applications of Cognitive Behavioural Therapy

CBT techniques are aimed mainly at correcting errors in information processing and modifying core beliefs that result in faulty conclusions. Examples of behavioural techniques typically used by cognitive therapists include skills training, role playing, behavioural rehearsal, and exposure therapy. Regardless of the nature of the specific problem, the cognitive therapist is mainly interested in applying procedures that will assist individuals in making alternative interpretations of events in their daily lives.

Cognitive therapy has been successfully used in a wide variety of other disorders and clinical areas, some of which include treating phobias, psychosomatic

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disorders, eating disorders, anger, panic disorders, stress and generalized anxiety disorders (Dattilio & Kendall, 2007). Others are posttraumatic stress disorder, suicidal behaviour, borderline personality disorders, narcissistic personality disorders, and schizophrenic disorders and divorce counselling (Dattilio & Freeman, 2007). CBT approach also focuses on family interaction patterns, and family relationships. Some cognitive behaviour therapists place a strong emphasis on examining cognitions among individual family members as well as on what may be termed the "family schemata" (Dattilio, 2006).

Researchers conducted proved that Cognitive Behaviour Therapy is efficacious in handling emotional disturbances including marital challenges. Beck (2011) indicated that Cognitive behaviour therapy has been extensively tested since the first outcome study was published in 1987 (Beck, 1987). More than 500 outcome studies have demonstrated the efficacy of cognitive behaviour therapy for a wide range of psychiatric disorders, psychological problems, and medical problems with psychological components (Beck, 2003). Studies have been conducted that demonstrate the effectiveness of cognitive behaviour therapy in community settings (Beck, 2003). Other studies have found computer assisted cognitive behaviour therapy to be effective (Khanna & Kendall, 2010). All these are indications that CBT is conducive in helping people to overcome psychological problems like marital distress.

Much attention has been given to studying the effectiveness of Beck's cognitive therapeutic approach to depression, as can be seen by several meta-analyses that evaluate it. Sharf (2012) pointed out that in a meta-analysis,

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examining 58 investigations; it was found that depressed clients benefited considerably from psychotherapy, with gains comparable to pharmacotherapy. Sharf (2012) again wrote that in a review of 72 studies of adults using randomized clinical trials, cognitive therapy helped patients significantly better when compared to waiting lists, antidepressants, and miscellaneous therapies. Additionally, a large-scale study-treatment for Adolescents with Depression Study (TADS) has shown that combining pharmacological treatment with cognitive and behavioural methods can be effective in helping depressed adolescents (Sharf, 2012).

In another study, depressed patients who did assigned psychotherapy homework were found to improve much more than patients who did little or no homework (Burns & Spangler, 1988). Interestingly, severity of depression did not seem to be a factor in whether or not patients did homework. Sharf (2012) reported that individuals who had participated in cognitive therapy suggested that relapse can be reduced by training patients to be intentional rather than automatic in the way they process unwanted thoughts. Rather than change their beliefs, they can label them as "events in the mind." In a study of 35 moderately, to severely depressed patients, relapse was also shown to be reduced by developing and using cognitive therapy techniques. Also comparisons have been made with other theories of therapy. Comparing person-centered therapy with cognitive therapy in a sample of 65 French patients, it was found that, patients in cognitive therapy were retained in therapy longer and showed better long-term improvement on global measures than those in person-centered therapy. Also, those in cognitive therapy

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showed earlier improvements in feeling hopeful and acting less impulsively than those in person-centered therapy.

In a review of the effectiveness of cognitive therapy with patients who have symptoms of generalized anxiety disorder, Beck (1994) concluded that cognitive therapy is successful in reducing individuals' perception of threat and reducing levels of distress. They reported that cognitive therapy has been more effective than behavioural or pharmacological therapy, especially in maintaining therapeutic change over time.

In a study of 35 outpatients with obsessive-compulsive symptoms, those who received cognitive therapy in addition to exposure therapy were less likely to drop out of treatment than those who received exposure treatment alone (Beck, 2011). In addressing the application of cognitive therapy to women, Johansen (2003) described how gender issues can be incorporated in dealing with women's concerns. With regard to treating women who are depressed, they also describe the challenge of using cognitive therapy to help women's dispute, their thoughts and beliefs, while at the same time recognizing the value of their own views. Because cognitive therapy is active and structured, therapists need to be careful not to take too much power or responsibility in the therapeutic contract.

Cognitive therapy can also be helpful to men because of several features, including an emphasis on problem solving. Johansen (2003) further found that men may be more comfortable with cognitive therapy's emphasis on thoughts rather than emotions unlike in the case of women. This is likely to be particularly true of men who are reluctant to express themselves emotionally. Also, men who are

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experiencing gender role conflicts may prefer, as some research evidence suggests a cognitive approach to treatment. Traditionally, men may also prefer the structured and action-oriented approach of cognitive therapy to others described in this text. Just as gender values and beliefs can be seen in cognitive therapy as gender schemas, so can cultural values and beliefs be viewed as cultural schemas.

Group CBT

The meta-study by Leahy (2006) examined 29 studies in the United States and other nations occurring between 1984 and 2008 which investigated the effectiveness of CBT for depression in people with a diversity of somatic diseases (such as cancer, HIV infection, multiple sclerosis, or renal failure). Participants were diagnosed as having depressive symptoms or depressive disorder as well as the somatic disease. The results also suggested that, while individual treatment might be more effective than group therapy in somatically ill people with depressive disorder, group therapy also reduces symptoms. Overall, CBT is effective in treating depressive symptoms in people with a variety of somatic diseases. There were other similar findings using CBT for groups.

VERITAS LUMEN NOBIS

The study, by Leahy (2006) sought to determine whether cognitive therapy has an enduring effect and to compare this effect against the effect produced by continued antidepressant medication. In outpatient clinics, patients who responded to CBT in a randomised controlled trial were withdrawn from treatment and compared during a 12-month period with medication, respondents who had been randomly assigned to either continual medication or withdrawal.

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Results showed that those withdrawn from CBT were significantly less likely to relapse during continuation than patients withdrawn from medications. The researchers concluded that CBT has an enduring effect extending beyond the end of treatment, seemingly as effective as keeping patients on medication. CBT has proven to be efficacious in many instances. CBT however has not yet been effective with issues such as comorbid alcohol or other substance disorders, some psychotic disorders, organic brain syndrome, and learning difficulties.

Counselling Clients with Marital Distress Using Cognitive Behavioural Therapy

By the time couples consider therapy, many of them might have also considered the option of divorce. Therapy can help to answer questions of whether or not the relationship can provide what each spouse needs for a satisfying marriage. Although there are a number of treatment programmes for unhappily married couples, the most widely researched form of treatment for marital distress is cognitive behavioural marital therapy. There are several general goals of this approach to marital therapy.

Firstly, spouses are taught how to identify and increase the number of caring behaviours they do for one another. Secondly, they are taught specific communication skills in order to improve the quality of their communication. Improving communication often produces greater emotional closeness and intimacy in the marriage. Thirdly, spouses are taught problem-solving skills so that they can successfully resolve problems in their relationship without getting into destructive arguments. Finally, they are taught how to improve the quality of their

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sexual relationship through sexual enhancement, as well as how to identify and modify unrealistic beliefs that may be contributing to their unhappiness.

Many studies have been conducted in the United States and in Europe to evaluate the effectiveness of cognitive behavioural therapy. Results have shown that about 65% to 75% of the couples treated with this method improve substantially at the end of treatment and maintain these gains following treatment. As with all forms of therapy, however, spouses must be committed to improving the quality of their relationship and be willing to make changes in themselves for therapy to be effective.

Because marital distress is so strongly associated with a variety of psychological problems, nearly 50% of all individuals who seek therapy do so because of marital problems. Research has shown that in addition to improving the quality of the marriage, cognitive behavioural marital therapy is an effective treatment for many psychological problems, including depression and alcoholism.

Finally, a number of studies have shown that behavioural premarital intervention programmes based on the same principles as behavioural marital therapy programmes are effective in helping couples develop and maintain a successful marriage (Association for Advancement Behaviour Therapy, 2014).

Limitations of CBT

Although CBT has been an effective therapy in reducing marital distress. Hammontree, (2016) enumerated a number of limitations of CBT. Among some of these limitations are:

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1. CBT may not be effective for individuals with more complex mental health issues or those with learning difficulties because the client needs to have the capacity to bring change to themselves.
2. CBT can be used with children, adolescents and adults, but tends to work best with older children and teens.
3. CBT has a narrow focus and ignores important issues like family, personal history and wider emotional problems.
4. Attending regular CBT sessions and carrying out extra work between sessions can be time consuming.
5. CBT focuses on the "here and now" so it may not address the possible underlying causes of mental health conditions.

Integrative Behavioural Couple Therapy (IBCT)

Integrative Behavioural Couple Therapy was formulated in an attempt to improve traditional Behavioural Couple Therapy. Christensen, Jacobson and Babcock (1995) viewed IBCT as couples therapy return to its radical behavioural roots and away from more cognitive stress. This movement, as Jacobson (1997) described it, was a move away from task analysis of skills that couples needed to perform to a more intensive focus on the functions of behaviours in the relational context. The theory has its origins in behaviourism and is a form of behaviour therapy. The theory is rooted in social learning theory and behaviour analysis. As a model, it is constantly being revised as new research presents. Integrative behavioural couple therapy (IBCT) was developed by Neil S. Jacobson and Andrew Christensen. The model represents a return to contextualism, functional analysis

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and Skinner's distinction between contingency shaped and rule governed behaviour (Christensen, Jacobson, & Babcock, 1995). Integrative Behavioural Couple Therapy is "integrative" in at least two senses: First, it integrates the twin goals of acceptance and change as positive outcomes for couples in therapy. Couples who succeed in therapy usually make some concrete changes to accommodate the needs of the other but they also show greater emotional acceptance of the other. Second, IBCT integrates a variety of treatment strategies under a consistent behavioural theoretical framework. It is considered a third generation behaviour therapy or sometimes called clinical behaviour analysis.

Another element that defines IBCT is that it integrates strategies promoting changes with methods for fostering acceptance and tolerance (Jacobson & Christensen, 1998). Working with these acceptance techniques is entirely new and a real challenge for the therapist who must learn to manage them skillfully, and at the same time, avoid a prior judgments about what concrete behaviours of each couple component should be modified or which should be invariably accepted although, of course, there are logical and ethical limits, such as not accepting abuse or harassment by the partner (Jacobson & Christensen, 1998; Dimidjian et al., 2008).

Jacobson, Christensen, Prince, Cordova, and Eldrige (2000) found that approximately 80% of couples responded to normal functioning in the IBCT group. On follow up, 67% of couples significantly improved their relationships for two years (Christensen, Atkins, Berns, Wheeler, Baucom, & Simpson, 2004). While 67% of couples in therapy experiencing clinically significant reliable change are a

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powerful effect, IBCT continues to refine its tenets and its treatment formulations. It is hoped that as this process continues, IBCT will be able to reach more and more of the remaining distressed couples. Recent research studies have placed IBCT as a likely efficacious treatment for couples' distress (Chapman & Compton, 2003).

In this vein, IBCT has recently attempted to observe its effectiveness with couples in which an extramarital affair is present (Atkins, Baucom, Eldridge, Christensen, 2003; Gordon, Baucom, & Snyder, 2000, 2004) and in recovery from an affair (Gordon, Baucom, & Snyder, 2000, 2004). IBCT includes strategies to help spouses accept aspects of their partners that were previously considered unacceptable. For couples who do benefit from the traditional approach, IBCT can facilitate further progress by providing an alternative way to establish a closer relationship, given that there are problems in every relationship that are impervious to change (Christensen, Jacobson, & Babcock 1995).

IBCT focuses on increasing emotional acceptance, as well as direct change, in partners. IBCT assumes that relationship problems result not just from the egregious actions and inactions of partners but also in their emotional reactivity to those behaviours. Therefore, IBCT focuses on the emotional context between partners and strives to achieve greater acceptance and intimacy between partners as well as make deliberate changes in target problems (Hayes, 2004).

The Christensen et al. (2004) study showed statistically and clinically significant improvement in both conditions at the end of treatment, with IBCT showing more consistent improvement throughout treatment. At a two-year follow-up, Christensen, Atkins, Yi, Baucom, and George (2006) found that approximately

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two thirds of couples were improved relative to pretreatment according to clinical significance criteria (69% of IBCT couples and 60% of TBCT couples). There were few significant differences between treatments, but the differences that did emerge tended to favour IBCT. Again, IBCT was developed, in part, to address concerns about long-term maintenance of gains (Jacobson & Christensen, 1998) through a focus on emotional acceptance and an emphasis on natural contingencies. For example, rather than teaching couples the "right way" to communicate and reinforcing that communication, as in TBCT, IBCT therapists process partners' reactions to each other's communication, letting those responses (natural contingencies) shape each other's behaviour. It is hypothesized that these strategies might bring about more durable change, especially in severely distressed couples.

IBCT assumes that there are genuine incompatibilities in all couples that are not amenable to change, those partners' emotional reactions to each other's behaviour are at least as problematic as the behaviour itself, and that a focus on change can often lead to a resistance to change. IBCT emphasizes nondirective, "contingency-shaped" changes (Skinner, 1966) cited in Dimidjian, Martell, & Christensen (2008). There have been three small empirical studies of IBCT. Wimberly (1998) demonstrated that 8 couples randomly assigned to a group format of IBCT were significantly more satisfied than 9 wait-list couples at the end of therapy. In another study of 29 depressed women who were maritally distressed, Trapp, Pace, and Stoltenberg 1997, cited in Christensen and Heavey (1999), showed that IBCT was as effective in reducing depression as cognitive therapy for depression. Finally, in a clinical trial of 21 couples that served as a basis for the

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current clinical trial, Jacobson, Christensen, Prince, Cordova, and Eldridge (2000) demonstrated that TBCT and IBCT could be distinguished when delivered by the same therapists according to independently coded measures of adherence.

Counselling Clients with Integrative Behavioural Couple Therapy

The therapy does not have a strict protocol, but it does have a well-defined structure, especially in the early sessions (Jacobson & Christensen, 1998), which could be outlined as follows:

First conjoint interview: The first face-to-face contact with the therapist is in a session with both partners together. An attempt is made to concentrate on the content of the couple's problems, as well as the strengths of their relationship. In some cases, it is suggested that they fill out questionnaires, such as the DAS (Spanier, 1976), the FAPBI (Christensen & Jacobson, 1997), or the MSI (Weiss & Cerreto, 1980) at home. It may also be recommended that the couple read an informative manual on the intervention (Christensen & Jacobson, 1997). This is to assist the couples to know the background of the instrument and how it works to assist the couple solve their differences.

Individual interviews with each partner: The two following sessions are individual sessions with each of the partners, in which an attempt is made to approach the problem and the current situation, and also the family-of-origin history, the relationship history and the present level of commitment.

Feedback session: After the sessions with each partner alone, the therapist invites both partners to come back, and presents the case formulation in a manner understandable by the couple, trying to corroborate it with them, refining it with

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their opinions, explaining the treatment and setting the goals of intervention. Case formulation has to do mainly with what has been called the "theme" (categories of conflictual behaviour with similar functions), the "polarisation process" (interaction patterns that are initiated when conflict around the theme occurs), the "mutual trap" (both partners feel stuck, discouraged and hopeless) and the "pragmatic truth criterion".

Therapy sessions: From this time on, it is attempted to orient the sessions toward conflict solution, based on the case formulation that was presented in the feedback session. This is organized starting out from recent incidents and arguments (from the last few days), that connect to the basic problems (present in the case formulation). Intervention techniques are gradually proposed (acceptance, tolerance or change, beginning with one or the other according to the status and needs of the couple) to help them overcome these situations.

Intervention strategies: As mentioned above, the intervention strategies consist of the already known traditional therapy (strategies for change) and the new, genuine IBCT strategies (acceptance and tolerance).

The acceptance strategies are used as tools to manage incompatibilities, the differences that seem irreconcilable or problems that are not getting solved. They are, therefore, a means of improving the relationship by attaining acceptance of what at first sight seemed unacceptable, was the cause of permanent unhappiness and seemed to make the relationship unfeasible. From the theoretical framework of the IBCT, the methods of acceptance are opposed to negative methods of change such as coercion, vilification or polarization. Therefore, in this context and in a

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technical sense, acceptance is not understood as resignation to the form of the relationship or yielding to a certain status quo, but as a hopeful alternative for couples who now face problems that are not manageable with known strategies for change. Acceptance must be understood as a method by which problems can serve as vehicles for improving intimacy and mutual proximity (Dimidjian et al, 2008). This acceptance also involves backing down in the struggle to try to change the other, which involves both detachments from the idea that mutual differences are unbearable, as much as abandoning the fight to shape the couple in the direction of the idealized image of husband/wife.

The first strategy, "empathic joining", consists of the partners learning to express their grief or distress in a way that does not include accusation. One way to generate this acceptance is by placing the behaviour of one partner in contact with his/her personal history. That is, what it does is to contextualise the behaviour that is considered problematic within the formulation that was made of the problem. Thus negative behaviour is seen as part of their differences.

The second, "unified detachment", is oriented toward helping the two partners to distance themselves from their conflicts and arguments by promoting an intellectual analysis of the problem and favouring impartial, descriptive dialogue (Dimidjian et al, 2008). This invites the couple to face the problem together. That is, it is a matter of their being able to talk about a negative incident when it arises as if it were "it". It is unified because the two have to get together (joined) to face the problem. For example: "We have a problem with where your mother is going

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to live", or in other words, decide where the mother lives is the problem the couple are facing (both together).

Tolerance strategies, on the other hand, would be on a different level from acceptance. They couple are to put this into practice when the above strategies have not worked as expected. The idea of tolerance strategy is that, if acceptance cannot be achieved, at least tolerate the other's behaviour as much as possible. In some cases, tolerance techniques can facilitate the path to acceptance. The procedures would be: pointing out positive features in negative behaviour, practicing negative behaviour in the therapy session, faking negative behaviours at home between sessions, and promoting tolerance through self-care.

Certainly, it is not easy to distinguish between the levels of tolerance and of acceptance. According to Jacobson and Christensen (1998), training in tolerance could be compared to an exposure technique in a conventional anxiety treatment. Analogously, the IBCT therapist would expose the members or the couple to the conflictive situations, first in a safe environment so the behaviour is tolerated better and the response to it is less intense. But if acceptance is not achieved this way (that is, they do not progress toward intimacy and comprehension through conflict), at least its adverse effects are lessened and the couple recovers more quickly from the conflict.

Finally, the change strategies are not different from those of the traditional couple therapy of Jacobson and Christensen (1998). So what they attempt to do is to increase or decrease the frequency or intensity of certain behaviours, and improve communication and joint decision making through training in

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communication and problem-solving skills. Of course, when the couples come with very coercive interactions, beginning with behavioural exchange is less likely, and the use of communication and problem-solving skills also co-assist in increasing acceptance.

In conclusion, treatment of marital distress for mild to moderate cases has been shown to be efficacious (Alexander, Holtzwork-Monroe & Jameson, 1994). However, in study after study, treatment effects have been found to drop off after one or two years (Christenson & Heavey, 1999) with the exception of one study of insight marital therapy which reported effects continued at a four-year follow up (Snyder & Wills, 1989). Numerous reasons for marital therapy not having more lasting effects have been suggested, including life-long difficulties in attachment and intractable interpersonal difference (Gottman, Rynn, Carrere & Erley, 2002). From a behavioural learning point of view, relapses may be a function of the return of environmental conditions that are similar to the conditions that initially shaped and maintained the dysfunctional behaviour. Whatever the causes, it seems apparent that marital therapy is not like surgery. If the surgeon removes an appendix, she or he can pretty well guarantee that the patient will never again have appendicitis. Nothing comparable occurs in marital therapy. Consequently marital distress appears to follow a pattern that is more chronic than acute.

The potentially chronic nature of marital distress has implications for treatment effectiveness. If martial distress is more chronic than acute, then it seems unreasonable to expect treatment to have long-lasting effects. Therefore future research might focus on helping couples to repair the relations and to adopt marital

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distress over the course of their relationship (Gottman et al, 2002; Johnson et al., 2001). In addition, research might focus on treatments for increasing effectiveness with more severely distressed and fitting treatments to a number of co-occurring problems, such as depression, anxiety and so on (Alexander et al, 1994).

EMPIRICAL REVIEW

Introduction

In examining how much distress, men and women experience in their marital relationships, and what psychosocial factors are associated with marital distress, the findings of Anim (2013) revealed that wives tested more distressed than husbands in marriages. Certain psychosocial areas that showed high distress in such marriages were communication, time spent together, sex relations, and friendliness.

In another study, Craighead, Craighead, Kazdin, and Mahoney (1994), summarizing some research findings, wrote that compared to non-distressed couples, distressed couples communicate with each other more negatively, both verbally and nonverbally. More negative behaviours such as put-downs, criticisms, disapproval, and disagreeing statements appeared in unhappy couples' communication. Positive behaviours such as supportive behaviours, responsiveness to partners in the form of paraphrasing, agreeing, or acknowledging, and "reconciling acts" such as using humor were less showed by distressed couples. Nonverbally, members of distressed partners smile less, keep more distance between each other, and have more closed body posture. People in distressed partnerships tend to reciprocate with negativity, that is to say, when one partner

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showed negative behaviour, the other partner would respond with another negative behaviour. Subsequently, distressed partners seem to be more reactive to negative events than happy partners. This tendency increases the likelihood of each partner feeling negatively about the relationship as a whole.

Another study conducted by Bradbury, Fincham, and Beach (2000) revealed that couple distress continues to number among the most frequently encountered difficulties. The divorce rate in America continues to hover around 50%, with half of these divorces occurring in the first 7 years of marriage. Rates of marital distress in presently married couples approximate 20% of couples at any time, with marital satisfaction decreasing considerably over the first decade of marriage

In a similar study, Whisman and Uebelacker (2006) evaluated associations between marital distress and DSM Axis I psychiatric disorders in a U.S. population-based survey of married individuals. They found that marital distress was associated with broad classifications of anxiety, mood, and substance use disorders and with all narrow classifications of those specific disorders except for panic disorder. The strongest associations obtained were between marital distress and bipolar disorder, alcohol use disorders, and generalized anxiety disorder. The report further stressed that over the last decade, considerable research has accrued, that suggests couple distress has a strong relation to an individual's level of mental and physical problems. Moreover, evidence is beginning to accrue that couple distress is not only correlated with but also has a causal role in the generation and maintenance of individual psychopathology. The effects of relationship distress are

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clearly salient not only in the individual but also throughout the family system. Whisman and Uebelacker (2006) also found that relationship distress is related to social role impairment with family and friends, impaired work functioning, general distress, poorer health, and increased likelihood of suicidal ideation.

Studies conducted by Whisman (2001) and Holtzworth-Munroe and Meehan (2004) conducted a study on the association between depression and marital dissatisfaction in Minnesota, USA. The study showed that marital distress leads to poorer treatment outcome in the treatment of problems such as depression, anxiety, and substance use disorders and in relapse following treatment. Thus, couple distress clearly has a pervasive effect on individual problems, and thus, it would behove clinicians and researchers to focus on treating individuals and screen for couple distress as well as address it if present.

Researches conducted by Whisman, Sheldon, and Goering (2000) conducted a study on psychiatry disorders and dissatisfaction with social relationship in Pennsylvania, USA. Their study revealed that couple distress co-varies with individual emotional and behavioural disorders above and beyond general distress in other close relationships. In comparison to happily married persons, maritally distressed partners are 3 times more likely to have a mood disorder, 2.5 times more likely to have an anxiety disorder, 2 times more likely to have a substance use disorder, and 5.5 times more likely to report problems of domestic violence. Moreover, couple distress, particularly negative communication has direct adverse effects on cardiovascular, endocrine, immune, neurosensory, and

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other physiological systems that, in turn, contribute to physical health problems (Kiecolt-Glaser & Newton, 2001).

Empirical Studies on the Use of IBCT

Research conducted by Christensen Atkins, Christensen, Atkins, Berns Wheeler, Baucom and Simpson (2004) on traditional versus integrative behavioural couple therapy for significantly and chronically distressed married couples, found out that there was statistically significant effects indicating improved relationship satisfaction, stability, and communication after IBCT intervention. The results of the study also show that 71% of distressed couples improved significantly after IBCT intervention as against 29% for TBCT intervention.

In similar studies, the findings of Christensen Atkins, Christensen, Atkins, Berns, Wheeler, Baucom and Simpson (2004) revealed that 54% of distressed couples show reliable improvement and 35.3% showed reliable improvement and also recovered fully after IBCT intervention. Jacobson, Christensen, Prince, Cordova and Eldridge (2000) conducted a study on integrative behavioural couple therapy, an acceptance-based, promising new treatment for couple discord. The results of the study indicated that IBCT produced as much or more change in couples going through marital distress.

A study conducted by Mairal (2015) on Integrative Behavioural Couple Therapy (IBCT) as a third-wave therapy revealed that IBCT helps to promote acceptance and tolerance in the area of behaviour exchange, communication training and couple problem solving. Furthermore, IBCT incorporates useful

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orientation for solving difficult problems in couples, such as infidelity, substance use and abuse as well as dependence situations.

Another study conducted by Christensen, Atkins, Baucom and Yi (2010) on marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioural couple therapy revealed statistically significant superiority of IBCT over TBCT in relationship satisfaction, but subsequent data showed increasing similarity and non-significant differences in outcome. After two years of treatment, IBCT produced substantial improvement in even seriously and chronically distressed couples.

In furtherance, many studies found IBCT to be more efficacious than CBT. Chilemba (2012) found in Tanzania that IBCT was more potent in dealing with marital dissatisfaction than CBT. He further indicated that although IBCT generally was more efficacious, females were more responsive to CBT than IBCT.

Suarez (2014) examined the impact of IBCT aand CBT on older couples in Mississippi, USA also found out that marital quality was significantly improved using IBCT than CBT on disenchanted marriages. He found that the two treatment groups had improved significantly than those in the control. Aluoch (2010) examined the effect of IBCT and CBT in improving marital success of married people in Mombasa, Kenya found out that IBCT was more efficacious than CBT in improving the marital success of married people. She revealed further that although IBCT was efficacious than CBT the difference between them was not significant in improving marital success.

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In addition, a study conducted by Cordova, Jacobson, and Christensen (1998) on the topic acceptance versus change interventions in behavioural couple therapy: impact on couples' in-session communication revealed that IBCT couples expressed more non blaming descriptions of problems and more soft emotions than TBCT couples during stages of therapy. IBCT couples significantly increased their non-blaming description of problems and significantly decreased their expressions of hard emotions and their problematic communication over time.

Mensah (2013) conducted a study on a comparison of CBT and IBCT in improving marital satisfaction of dissatisfied couples in Agogo, Ghana, had a contrary finding that CBT was more effective in improving their satisfaction levels than IBCT. He added that the difference between the two groups was statistically significant. Olara-Okello (2014) also conducted a study on improving marital quality of couples through CBT and IBCT in Entebe, Uganda. The study revealed that CBT was more efficacious than IBCT in managing marital distress. He revealed that although both therapies were found to be efficacious in managing marital distress, CBT was more efficacious. He added that marriages near divorce needed IBCT more than CBT as he found that couples whose marriages are near divorce needed acceptance and change.

Empirical Studies on the Use of CBT

Lebow (1995), conducted a study on the treatment of couple distress. The results revealed that cognitive behavioural therapy positively impacts 70% of couples receiving treatment. The effectiveness rates of cognitive behavioural therapy are comparable to the effectiveness rate of individual therapies and vastly

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superior to control groups not receiving treatment. The relationship between couple distress and individual disorders such as depression and anxiety has become well established over the past decade. The research also indicates that cognitive behavioural therapy clearly has an important role in the treatment of many disorders and is very promising in handling marital distress.

Ansah (2011) conducted a study on the impact of CBT on marital quality of married people in Breman Asikuma, Ghana. The study found only CBT to be effective in improving the marital quality of married people who went through premarital counselling even though he made use of IBCT as well. Ansah holds the opinion that fragmented minds of couples were the results of non-professional counsellors who had taken these married individuals through counselling. The CBT therefore helps in pulling the minds of the married people together and shaping their thought patterns.

Mami, Roohandeh and Kahareh (2015) conducted a study on the effectiveness of Cognitive Behavioural Therapy on marital intimacy and life satisfaction in couples. The findings suggest that cognitive behavioural therapy increases the intimacy of marriage and life satisfaction compared to the control group. In other words, dysfunctional attitudes of those who participated in the sessions of CBT group compared with the control group had a significant increase. This result is consistent in line with the findings of Saemi (2005) who found out that CBT skills can help couples in dealing with the problems of family, social, economic, employment, etc., which are part of everyday tasks, communicate better, and this leads to an increase intimacy and life.

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Similarly, Hiltunen, Kocys, and Perrin-Wallqvist (2013) conducted a study on the effectiveness of Cognitive Behavioural Therapy: an evaluation of therapies provided by trainees at a university psychotherapy training centre. The findings of the study revealed that CBT is effective for treatment in many problem areas (Butler, Chapman, Forman, & Beck, 2006). Approximately 80 distinct and empirically supported CBT techniques have been identified by O'Donohue and Fisher (2008) and shown to be effective for various problem areas, including anxiety disorder, depression, skills acquisition, parent training, enuresis, development of assertive skills, pain management, stress management, classroom management, insomnia, social skills training, and problem solving skills (O'Donohue & Fisher, 2008).

Aghdam (2017) conducted a study to determine the effectiveness of Cognitive Behavioural Therapy on the reduction of marital disaffection of women filing for divorce in Tehran. The semi-experimental research with a pretest-posttest design with a control group was employed to conduct the study. The study randomly sampled 30 women and these women were randomly assigned to experimental and control groups. Both groups were pretested before the intervention. Participants in the experimental group were taken through eight CBT sessions, whereas those in the control group did not participate in any kind of training. At the end of the intervention, both groups were post tested. The findings of the study indicated that the marital disaffection scores of women participating in the CBT sessions has been significantly lower than that of the women in the control group, $F\ (1, 27) = 141.24, p < 0.001$ at a 1-percent alpha level. It must however be

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noted that this study concentrated on only females. The current study comprises both male and female married couples. Again, Aghdam used a sample of 15 in each group, and also the Marital Disaffection Scale, which is a 21-item scale was used. The scale mainly has three sub-scales: physical exhaustion, emotional exhaustion, and mental exhaustion. The study therefore used a sample of 20 participants in each group which is more than what was used previously. In effect this will enhance the validity of the results. Further, the study has 120 items which appears to measure more of the traits of marital distress than that of Aghdam. In all, the current study seeks to provide a new dimension by increasing the sample size, varying the instrument to include more traits, and using a lower confidence interval.

The research conducted by Cho et al. (2008) also showed that CBT is effective when it comes to reducing automatic negative thoughts, dissatisfaction with mutual relationships and overall marital dissatisfaction.

Salarifar (2014 as cited in Ammari, Amini, & Rahman, 2016), in a study dealt with designing cognitive-behavioural couple therapy and comparing its effectiveness with increasing couple marital satisfaction. The results of his study showed that CBT had significant effects on increasing marital satisfaction of the couples. In furtherance, Amani (as cited in Ammari, Amini, & Rahman, 2016) in a study compared the effectiveness of emotionally focused couple therapy, CBT and integrated emotional-cognitive-behavioural therapies regarding the changes in marital satisfaction and depression in Hamadan women. He found out that all the three methods helped to increase marital satisfaction and reducing the depression in women. Also, Dillon (2005), in a comparison between the effectiveness of

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Cognitive Behavioural Couple Therapy and the rights of spouse from Islam point of view in increasing compatibility and group marital satisfaction in married young women showed that both methods are effective in increasing the compatibility and marital satisfaction.

However, Asase-Gyima (2014) conducted a study on the effect of CBT in improving the marital quality of distressed couples in Tema, Ghana. The study found CBT to be ineffective in improving the marital quality of divorced couples. He found that after treatment, only 1 out of the 7 couples he treated desired to remarry their divorced spouses. What Asase-Gyima's study failed to do was to bring to bear reasons that accounted for his findings. The researcher strongly believes that fidelity on the part of the therapist might have accounted for this finding coupled with other challenges such as the length of the intervention convenience of the experimental setting.

Limitations of IBCT

The following were some of the limitations of IBCT in the perspective of Neil, Christensen, Stacey, Cordova, and Eldridge. (2000):

1. Therapy takes a lot of work on the part of both partners
2. The process is not easy and may be emotionally painful at some points along the line
3. Reverting certain issues may worsen issues. One partner may feel hurt.
4. Therapy session does not guarantee a happy ending. Some partners may still separate after treatment

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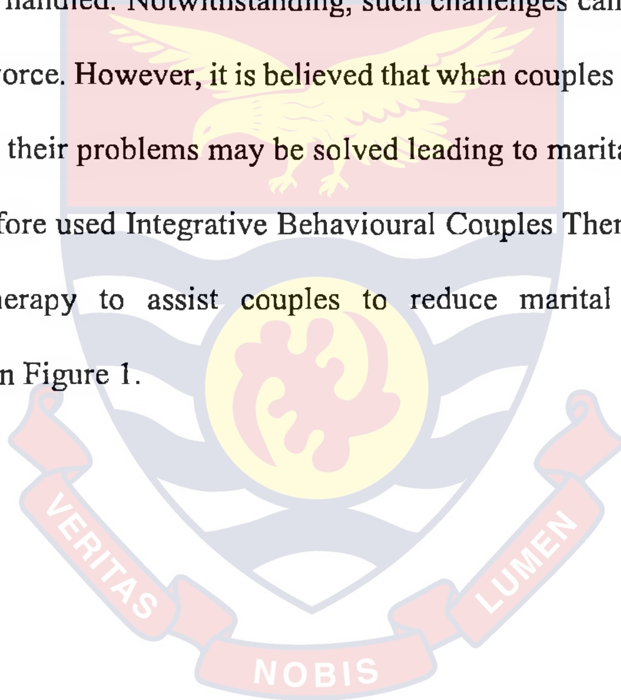
5. Not all couples are appropriate for IBCT. This is because there is a more pressing issue that is impacting the relationship and need to be solved first
6. Others don't change because of current domestic, substance abuse and addiction, severe mental illness (such as depression and mania).

CONCEPTUAL FRAMEWORK

Many couples face marital distress that they work through. Such challenges do not naturally lead to divorce, but can even strengthen the relationship, depending on how they are handled. Notwithstanding, such challenges can eventually lead to separation or divorce. However, it is believed that when couples subject themselves to interventions, their problems may be solved leading to marital satisfaction. The researcher therefore used Integrative Behavioural Couples Therapy and Cognitive Behavioural Therapy to assist couples to reduce marital distress. This is conceptualized in Figure 1.



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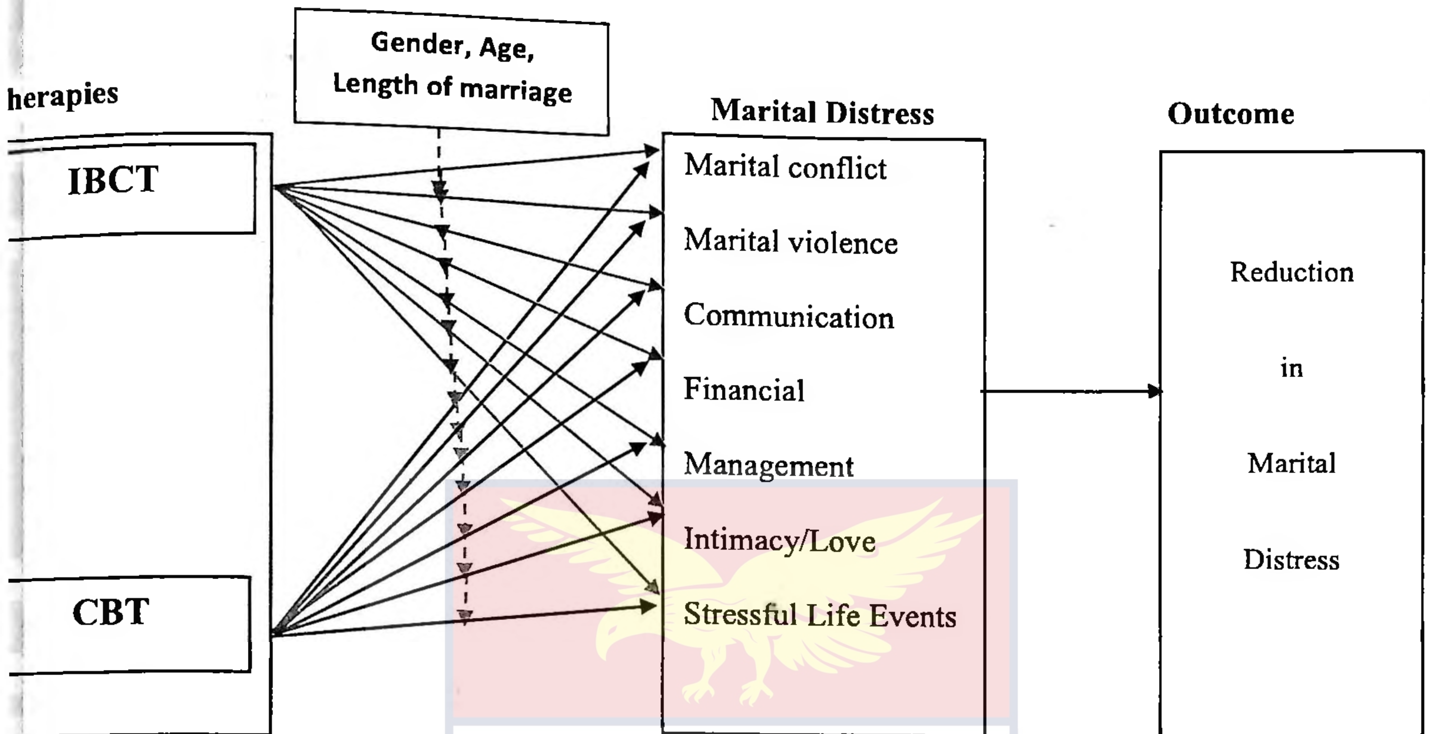

Figure 1- **Conceptual framework showing CBT and IBCT used as interventions for reducing marital distress.**

Source: Author's construct based on literature

Figure 1 shows the two interventions; Integrative Behavioural Couple Therapy (IBCT) and Cognitive Behavioural Therapy (CBT) as the two independent variables that is hoped to reduce marital distress which is the dependent variable. The areas of marital distress selected according to literature included Marital conflict, Marital violence, Communication difficulties, Financial management, Intimacy and love concerns as well as Stressful life events. The researcher projects that when distressed couples are taken through these therapies, their distressed levels will reduce. The researcher will manipulate the independent variables (IBCT and CBT) in order to observe the effect they would have on the dependent variable (Marital Distress). It is hoped that the manipulation of the independent variables (IBCT and CBT) will lead to a reduction in marital distress (dependent variable).

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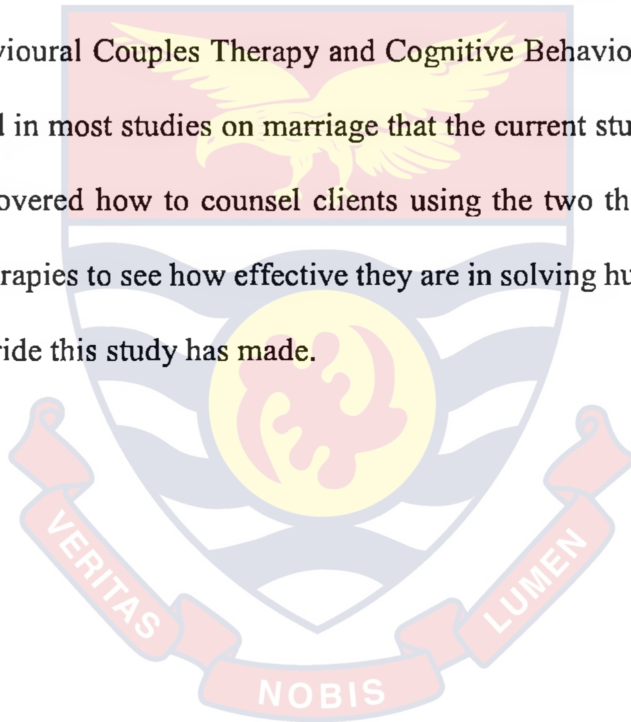
Further, the researcher also used age, gender and length of years in marriage as moderating variables to see if these variables could influence the reduction of marital distress among participants of the study.

Summary

The literature review covered the concept of marriage, what marital distress entails, the effects of marital distress, how to manage marital distress as well as the role of counselling in reducing marital distress. The elaborations on the use of Integrative Behavioural Couples Therapy and Cognitive Behavioural Therapy are key issues missed in most studies on marriage that the current study has provided. The study also covered how to counsel clients using the two therapies. Testing psychological therapies to see how effective they are in solving human problems is seen as a great stride this study has made.



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CHAPTER THREE

RESEARCH METHODS

Introduction

The purpose of this study was to ascertain whether using Integrated Behavioural Couples Therapy and Cognitive Behavioural Therapy as intervention strategies could reduce marital distress among Pentecost Christian couples in Ghana. This chapter dealt with the research procedure and explained the methods used to conduct the study. It comprised the research design, population, sample and sampling procedure, data collection instrument, validity of instrument, procedure of data collection, and the mode of data analysis.

Research Design

This study was a quasi-experimental research. The pre-test, post-test control group design was used for the study. A quasi-experiment is an empirical study used to estimate the causal impact of an intervention on its target population without random assignment. Quasi-experimental research shares similarities with the traditional experimental design or randomized controlled trial, but it specifically lacks the element of random assignment to either the treatment or control group. Instead, quasi-experimental designs typically allow the researcher to control the assignment to the treatment condition, by using some criterion other than random assignment (Dinardo, 2008). Leedy and Ormrod (2010) also opined that in quasi-

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experimental research, the researcher manipulates the independent variable and examines its effects on another, the dependent variable.

In some cases, the researcher may have control over assignment to treatment. Quasi-experiments are subject to concerns regarding internal validity, because the treatment and control groups may not be comparable at baseline. With random assignment, study participants have the same chance of being assigned to the intervention group or the comparison group. As a result, differences between groups on both observed and unobserved characteristics would be due to chance, rather than to a systematic factor related to treatment (e.g., illness severity). Randomization itself does not guarantee that groups will be equivalent at baseline. Any change in characteristics post-intervention is likely attributable to the intervention. With quasi-experimental studies, it may not be possible to convincingly demonstrate a causal link between the treatment condition and observed outcomes. This is particularly true if there are confounding variables that cannot be controlled or accounted for (Creswell, 2005).

A true experiment on the other hand is a method of social research in which there are two kinds of variables. The independent variable is manipulated by the experimenter, and the dependent variable is measured. Unlike quasi-experiment, the signifying characteristic of a true experiment is that it randomly allocates the subjects to neutralize experimenter bias, and ensures, over a large number of repetitions of the experiment, that it controls for all confounding factors. That is to say, true experimental designs are characterized by the random selection of participants and the random assignment of the participants to either the treatment or control groups

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in a study. The researcher also has complete control over the extraneous variables. Therefore, it can be confidently determined that effect on the dependent variable is directly due to the manipulation of the independent variable. For these reasons, quasi-experimental designs are often considered the best type of research design for this type of study. Figure 2 presents a pictorial illustration of the quasi experimental method.

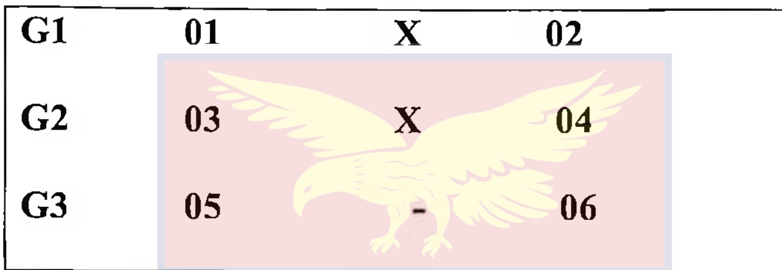

Figure 2- **Illustration of Quasi-Experimental Design**

Adapted from Awabil et al. (2013)

Interpretations

G1 stands for Treatment group 1 (CBT Counselling)

G2 stands for Treatment group 2 (IBCT Counselling)

G3 stands for Control group

O1 stands for Pretest (CBT Counselling)

O2 stands for Posttest (CBT Counselling)

X stands for Treatment

O3 stands for Pretest (IBCT Counselling)

O4 stands for Posttest (IBCT Counselling)

O5 stands for Pretest (Control Group)

\- stands for No Treatment (Control Group)

O6 stands for Posttest (Control Group)

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Pretest refers to collection of data before the commencement of the experiment while posttest denotes collection of data after the experiment.

Advantages/Strengths of Quasi-experimental Design

1. Since quasi-experimental designs are used when randomization is impractical and/or unethical, they are typically easier to set up than true experimental designs, which require random assignment of subjects.
2. Utilizing quasi-experimental designs minimizes threats to ecological validity as natural environments do not suffer the same problems of artificiality as compared to a well-controlled laboratory setting.
3. Since quasi-experiments are natural experiments, findings in one may be applied to other subjects and settings, allowing for some generalizations to be made about the population.
4. This experimentation method is efficient in longitudinal research that involves longer time periods which can be followed up in different environments.
5. Another advantage of quasi-experiments concerns the idea of having any manipulations the experimenter so chooses. In natural experiments, the researchers have to let manipulations occur on their own and have no control over them whatsoever.
6. Lastly, using self-selected groups in quasi-experiments also takes away to chance of ethical, conditional concerns while conducting the study (Derue, 2012).

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Disadvantages/ Weaknesses of Quasi-experimental Design

1. Quasi-experimental estimates of impact are subject to contamination by confounding variables (Dinardo, 2008).
2. The lack of random assignment in the quasi-experimental design method may allow studies to be more feasible, but this also poses many challenges for the investigator in terms of internal validity. This deficiency in randomization makes it harder to rule out confounding variables and introduces new threats to internal validity.
3. Because randomization is absent, some knowledge about the data can be approximated, but conclusions of causal relationships are difficult to determine due to a variety of extraneous and confounding variables that exist in a social environment.
4. Even if these threats to internal validity are assessed, causation still cannot be fully established because the experimenter does not have total control over extraneous variables.
5. Another disadvantage is that the study groups may provide weaker evidence because of the lack of randomness. Randomness brings a lot of useful information to a study because it broadens results and therefore gives a better representation of the population as a whole.
6. Finally, using unequal groups can also be a threat to internal validity. If groups are not equal, which is sometimes the case in quasi-experiments, then the experimenter might not be positive what the causes are for the results (Morgan, 2000).

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Justification for quasi-experimental design

Quasi- experimental design was adopted for the study because the setting prohibits the formation of artificial groups. Like true experimental designs, quasi-experiments include assignment, but not random assignment of participants to groups. This is because the experimenter cannot artificially create groups for the experiment. Again, since the researcher seeks to use human beings for the study, controlling the activities of these human beings may be a challenge. The nature of the study cannot permit the researcher to camp the participants of the study under a controlled environment, hence the need for the researcher to adopt the quasi-experimental design.

However, they provide necessary and valuable information that cannot be obtained by experimental methods alone. Also the design is preferred because its approaches may reduce the time and resources required because extensive pre-screening and randomization was not required or utilized. Also, where the sample is small and randomization is not possible, as in the case of this study, this design is preferred. It is also suitable for real natural world setting. It allows the researcher to evaluate the impact of quasi-independent variables under naturally occurring conditions.

Quasi- experiments work well in natural settings (Schoenfeld, 2006). Though the design lacks random assignment and suffers selection biases, its purpose is to select participants with certain characteristics to be studied. Nevertheless, quasi-experiments still provide fruitful information for the advancement of research (Leedy & Ormrod, 2010). Researchers Glazerman, Levy, and Myers (2002)

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concluded that quasi-experiments, when compared to true experiments, often result in substantially different findings. Such differences were however, considerably smaller for high quality quasi-experiments. Thus, quasi-experiments are based on creative design techniques to reduce the various threats that may cause the study's findings to be invalid or unreliable (Green, 2006).

Finally, the researcher used this design because he wants to use integrative couple's behavioural therapy and cognitive behavioural therapy on clients going through marital distress. Two groups were taken through the two therapies respectively while the third group was held constant, giving no form of treatment.

Population

The population for the study was made up of all Christian married couples in the Central Region of Ghana. Specifically, the accessible population was drawn from Christian married couples going through marital distress in two Pentecost churches in the Cape Coast Metropolis numbering 655 members. These two churches were selected because of the high rate of marital distress resulting in separation and divorce. Secondly, the Ministers of these churches expressed their interest in the study with the hope that the results of the study will help them in reducing the increasing spate of separation and divorce in their churches. Thirdly, Ministers from other churches were not willing to allow the researcher to use their members for the study, with the simple reason that their prayers will prevent marital distress among married couples in the church.

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Sampling Procedures

The study made use of an initial sample of 215 participants constituting married couples from the two Pentecost churches purposively selected. These were the people who expressed their interest to participate in the study. Out of this, the researcher purposively sampled 60 participants who were severely distressed, using a compendium of instruments on Conceptualising and Measuring "Healthy Marriages" for Empirical Research and Evaluation Studies (Carrano, Cleveland, Bronte-Tinkew, & Moore, 2003) as a screening tool (Task One Part II). This number was randomly assigned to each of the three groups of 20 participants (10 couples in each group). The researcher selected this sample size because in general, sample size depends on the nature of the analysis to be performed, the desired precision of the estimates one wishes to achieve, the kind and number of comparisons that were made, the number of variables that have to be examined simultaneously and how heterogenous a universe is sampled. As noted by Salant and Dillman (1994), if the key analysis of a randomised experiment consists of computing averages for experimentals and controls in a project and comparing differences, then a sample under 100 might be adequate.

The first group of 20 distressed participants was taken through Integrative Couple's Behavioural Therapy, the second group was taken through Cognitive Behavioural Therapy, while the third group was the control group which was not given therapy of any sort. Purposive sampling procedure was employed to select the sample for the study. According to Cohen, Manion and Morrison (2003), the researcher using purposive sampling handpicks respondents on the basis of

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judgment and typicality. In support of this, Creswell (2005) stated that in purposive sampling, the researcher intentionally selects individuals and sites to learn or understand the central phenomenon. The goal of purposive sampling is to select cases that are likely to be 'information-rich' with respect to the purpose of the study (Gall, Borg & Gall, 1996). The purposive sampling procedure was used because the study is restricted to married couples and those undergoing distress in their relationships.

Eligibility for the study

To be eligible for the study, couples had to be legally married and living together. They were also supposed to be between the ages of 21 and 60 years old. In addition, they were required to score 366-480 (representing severe marital distress) or 486-600 (representing very severe marital distress) on the Marital Distress Scale used for the study. This is consistent with a study conducted by Jacobson, Christensen, Prince, Cordova and Eldridge (2000).

Data Collection Instrument

A compendium of instrument on Conceptualising and Measuring "Healthy Marriages" for Empirical Research and Evaluation Studies (Task One Part II), developed by Carrano, Cleveland, Bronte-Tinkew and Moore (2003) was adapted and used to select clients going through marital distress. This instrument covers a wide range of marital challenges such as Relationship/marital violence, Sexual Intimacy, Attitudes to Marriage and Work, Commitment, Communication, Marriage and Financial Management, Marriage and Stressful Life Events, Relationship/Marital Satisfaction, Trust and Attitudes to Marriage/Relationships.

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However for the purpose of this study, the researcher used the instrument on Relationship/Marital Conflict, Relationship/Marital Violence, Communication difficulties, Marriage and Financial Management, Intimacy/Love concerns and Marriage and stressful life events. These areas were selected in line with the causes of marital distress as reviewed in the literature. The researcher has selected these six areas as they might be crucial in measuring marital distress. The instrument was adapted in the following ways from the original instrument.

Marital Conflict

1. Item number 2 which had its original form as "my partner stomped out of the house or yard during a disagreement" was adapted to "my partner went out of the house or yard during a disagreement"
2. Also, item number 4 which had its original form as "my partner insulted or shamed me in front of others" was changed to "my partner yelled or shamed me in front of others."
3. Item number 12 which had its original form as "my partner was insensitive to my sexual needs" was changed to "my partner was insensitive to my sexual needs and desires."

Marital Violence

1. Item number 6 which had its original form as "my partner beats me so hard, I must seek medical help" was adapted to "my partner beats me so hard that I must seek medical help."

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2. Item number 7 which also had its original form as "my partner physically throws me around the room" was changed to "my partner pushes me around violently."
3. Item number 14 which had its original form as "my partner tries to suffocate me with pillows, towels or other objects" was adapted to "my partner tries to suffocate me with pillows and towels."
4. Item number 15 which also had its original form as "my partner knocks me down and then kicks or stamps me" was changed to "my partner knocks me down and then kicks or stamps over me."

Stressful life events

1. Item number 9 in this aspect of the instrument which had its original form as "you became unemployed or you were seeking work unsuccessfully for more than one month" was adapted to "you become unemployed or you were seeking work unsuccessfully for more than one year"
2. Item number 15 which had its original form as "a close family friend or another relative (aunt, cousin, rand parent) died" was changed to " death of husband or wife's parent or close relative"
3. In furtherance, item number 17 which had its original form as "you had a serious problem with a close friend, neighbour or relative was changed to "a serious illness, injury, or assault happened to a close relative."

The scale on Relationship/Marital Conflict, Relationship/Marital Violence, Communication, Marriage and Financial Management, Intimacy/Love, Marriage

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and stressful life events were all made up of 20 items each; totaling 120 items in all. All the instruments were scored on a five-point Likert- type scale as follows;

Relationship/Marital Conflict

1 = Never
2 = Rarely
3 = occasionally
4 = Frequently
5 = Very frequently

Relationship/Marital Violence

1 = Very rarely
2 = A little of the time
3 = Some of the time
4 = Most of the time
5 = All of the time

Communication (a)

1 = Strongly agree
2 = Moderately agree
3 = Neither agree nor disagree
4 = Moderately disagree
5 = Strongly disagree

Communication (b)

1- Almost never
2- Once in a while
3- Sometimes
4- Frequency
5- Almost always

Marriage and Financial Management

1 = Strongly agree
2 = Moderately agree
3 = Neither agree nor disagree
4 = Moderately disagree
5 = strongly disagree

Intimacy/Love

1 = Occasionally
2 = Sometimes
3 = Frequently
4 = Almost
5 = Always

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Marriage and stressful life events

1 = Strongly agree
2 = Moderately agree
3 = Neither agree nor disagree
4 = Moderately disagree
5 = Strongly disagree

Scoring of instrument

Scoring the instrument has been categorised into low, moderate, severe and very severe depending on the score the respondent obtained. Respondents who scored between 20-40 were described as having low marital distress and were excluded. Those who scored between 41-60 were described as having moderate marital distress. Respondents who scored between 61-80 were described as having severe marital distress and those who scored between 81-100 were described as very severely distressed maritally. This is represented in Table 1

Table 1- *Scale for Scoring*

Total Score	Distress Severity Level
20-40	Low
41-60	Moderate
61-80	Severe
81-100	Very severe

The scores of individual respondents were collated to determine their position in terms of the degree or level of severity so far as the six areas of marital distress stated in the instrument are concerned. For example, a respondent who had the following in all the six areas, will have a summary of scores indicated in Table 2.

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Table 2- *Summary of Scores*

Area of distress	Scores	Description
Marital Conflict	50	Moderate
Marital Violence	20	Low
Communication	90	Very Severe
Marriage and Financial Management	80	Severe
Intimacy/Love	90	Very Severe
Marriage and stressful life events	60	Severe
Total	390	

As represented in Table 3, the respondent who scored 50, 20, 90, 80, 90 and 60 in all the six areas will have a grand score of 390. This places such a respondent between the ranges of 366-480, which represents severe marital distress as represented in Table 3.

Table 3- *Final Determinant Scale for Distress Severity Level*

Total Score	Distress Severity Level
120-240	Low
256-360	Moderate
366-480	Severe
486-600	Very severe

Reverse Scoring of Some Items

The following items were reversed scored.

Section B- Causes of Marital Distress

Marital Conflict

7. My partner helped me with housework when asked

20. My partner prepares meal on time

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Communication

1. It is not very easy for me to express all my true feelings to my partner.
7. My partner is not a good listener

Marriage and Financial Management

2. We always argue on how to use our money
5. We are both aware of our major debts and they are not a problem to us
6. We keep records of our spending so that we can budget our money
9. I am satisfied with our decisions about how much we should save

Validity and reliability of the research instrument

In order to determine the validity of the instrument, the instrument was given to the supervisors and five (5) other experts in the field of counselling to vet. This helped to ensure that the instrument measured exactly what it purports to measure.

The original instrument had Cronbach's alpha reliability coefficients ranging from .82 to .95, and with an overall coefficient of .88. A pilot testing was done to determine the reliability of the instrument, since the instrument was adapted. The Cronbach's coefficient alpha reliability of the instrument was .846. This is an indication of the internal consistency of the instrument. Some of the items were reviewed after the pilot testing. The pilot testing was conducted in two Pentecostal churches in Takoradi. Takoradi was selected because it has similar characteristics like Cape Coast. Both cities are situated along the coast, have fishing as the local occupation, both are Metropolis and also have the issue of marital distress leading to separation and divorce in the region. The two Pentecostal

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churches selected for the pilot testing expressed their interest to participate in the study. In all, Forty-five (45) married Christian couples who were living together completed the pre-test instrument out of which fifteen (15) couples who were severely distressed were selected to participate in the study. These 15 couples were randomly assigned in the groups. Group one for IBCT, group two for CBT and group three which was the control group was held constant. The intervention lasted for four weeks using both therapies. Results of the pilot testing showed that IBCT and CBT were both effective in reducing marital distress of participants. Again, IBCT proved more effective as compared to CBT. All the six dimensions of the scale were significant. However, age, gender and length of years in marriage were not significant in reducing marital distress of participants. Table 4 shows the reliability co-efficient of the various sub-scales of the original instrument and the adapted instrument.

Table 4- *Reliability Co-Efficient of the Original and Adapted Instruments*

No.	Name of Scale	Number of Items	Coefficient (Original)	Coefficient (Adapted)	Mean	Standard Deviation
1.	Marital Conflict	20	.951	.930	48.240	16.477
2.	Marital Violence	20	.830	.969	26.571	12.664
3.	Communication	20	.903	.769	30.340	8.456
4.	Financial Management/Difficulties	20	.820	.705	30.120	7.216
5.	Intimacy/Love	20	.87	.795	71.280	24.560
6.	Marriage and Stressful Life Event	20	.92	.907	70.140	20.415
	Overall	120	.882	.846	381.783	24.154

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Data Collection Procedures

The instrument was administered by the researcher and his team of research assistants. The researcher sought ethical clearance from the Institutional Review Board of the University of Cape Coast and has also obtained an introductory letter from the Guidance and Counselling Department before collecting data for the study. The instrument was administered to Christian married couples in two Pentecost Churches for easy accessibility. The instrument was administered to 200 married couples from which the researcher had the 60 participants needed for the study. The scores of the instrument determined the couples that were suffering from marital distress.

Those who were severely distressed (60 respondents) were the couples that were invited to participate in the study. These 60 participants were distributed into three groups. Two groups were offered counselling using the Integrative Behavioural Couples Therapy and Cognitive Behavioural therapy respectively. The third group was held constant. Posttest of the instrument was done at the end of the intervention to measure the effect of the therapies.

Control of variables (Threats to validity)

Selection: Participants were not matched when they were being assigned to the control and experimental groups. In this case, it was likely highly distressed participants may dominate in one group or vice versa. Though this seemed to be a threat, initial comparison of the pre-intervention scores of participants showed no difference among the experimental and control groups, which implies that selection, as a threat to internal validity, was reduced.

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Mortality: This is a situation where participants drop out in the course of the study. This threat was actually taken care of since there was no attrition in this study.

Diffusion of treatment: This is the case where participants in the control and experimental groups communicate with each other. This communication can influence how both groups score on the outcomes. In this study, the effect of communication between participants was reduced, since it was ensured participants in any of the groups did had no knowledge about their counterparts in the other groups.

Compensatory rivalry/resentful: These threats were taken care of since while participants in the experimental group were receiving the intervention, those in the control group were equally going about with their normal activities. However, after the study, participants in the control group were taken through IBCT and CBT.

Instrumentation: This was not a threat to this study, since the same instrument was used for both pre-test and post-test.

Maturation: This refers to physical/biological changes or mental which may occur within the subjects over a period of time. The use of control group in this study helped to control for maturation. This in the sense that participants in the control group may also experience similar physical/biological changes or mental changes as those in the experimental groups.

History: The use of control group helped to control this threat, since participants in the experimental and control groups may have similar experiences as far as history is concern.

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Data Processing and Analysis

The data were analyzed with both descriptive and inferential statistics. Mean, standard deviations and other descriptive statistics were computed to describe the data. The hypotheses were tested with the two-way mixed ANOVA, two-way ANOVA and one-way MANOVA. All hypotheses were tested at 0.05 significant level. All the analysis was done with the help of SPSS (version 22.0).

Justification of choice of analytical procedure

There are several approaches for comparing groups with pre-test and post-test data in quasi experimental design. These include ANOVA on change or gain scores, repeated measures ANOVA (Mixed factorial design), GLM with covariate, or Analysis of Covariance (ANCOVA) and ANOVA on residual scores. In all these methods, the use of pretest scores helps to reduce error variance, thus producing more powerful tests than designs with no pretest data (Stevens, 1996). Interaction of pretesting and treatment comes into play when the pretest sensitizes participants so that they respond to the treatment differently than they would with no pretest. The different approaches are discussed briefly and the rationale for using the two-way mixed factorial and MANOVA on gain scores for the dimensions in this study is provided.

The ANOVA (or MANOVA) on Change or gain Scores approach involves change score (difference between the post-test and pre-test scores) as the dependent variable in an ANOVA that compares the groups in the study. This reduces the problem from a multivariate test to a univariate, with the change scores interpreted as net gain or loss. A challenge with this approach occurs when regression toward

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the mean occurs. Regression toward the mean is when a first measurement of a variable is an extreme value it will tend to be closer to average on its second measurement, "averaging out" (Bland, & Altman, 1994). When this is not the case, the change scores approach provides reliable results (Dimitrov & Rumrill, 2003). The data in this study did not have the problem of regression toward the mean, and so this approach was used to test the hypothesis on the effect of the interventions on the dimensions of marital distress. Dimitrov and Rumrill further intimated that the reliability of gain scores approach is high in many practical situations, particularly when the pre-test and posttest scores do not have equal variance and equal reliability.

The second approach, *Repeated Measures ANOVA (Mixed factorial design)*, uses pre-test and post-test data as a mixed factorial design with one between-subjects factor (treatment group) and one within-subjects factor (pretest-posttest) (Bonate, 2000). This enables the researcher to test both the between and within subjects effects in one test. The interaction between the treatment factor and pretest-posttest factor, (i.e. the parameter of interest to detect group differences over time) is equivalent to the treatment main effect within a one-way ANOVA on change scores (Dimitrov & Rumrill, 2003). Specifically, the *F* test for the treatment main effect (which is of primary interest) is very conservative because the pretest scores are not affected by the treatment. This method is also very reliable in the absence of regression toward the mean.

The General Linear Model (*GLM) with covariate* (ANCOVA approach) is generally considered to be the most preferred approach of pre-test/post-test data. In

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this framework, the pretest scores are used as covariate to eliminate any systematic bias and reduce error variance. This method implicitly takes into account regression toward the mean. The outcome measure in a GLM may be either the raw posttest scores or change scores, as they will yield exactly equivalent results for the treatment effect. This test however, just like many parametric tests, requires satisfying certain assumptions for the results to be reliable. These include randomization, homogeneity of regression slopes, pretest measurement reliability, and a linear relationship between pretest and posttest scores (Dimitrov & Rumrill, 2003).

Though the ANCOVA approach has been generally preferred in pre-test posttest randomized control designs and would have been the preferred approach for the first hypothesis in this study, the data did not satisfy the assumptions for the ANCOVA approach as indicated below. The normality, homogeneity of regression slope and linear relationship between the outcome variable (post-intervention) and covariate were all violated. This therefore rendered the ANCOVA approach inappropriate for this study. Violation of the normality and homoscedasticity assumptions can have substantial influence on the results of classic parametric tests, in particular on rates of Type I and Type II error (Erceg-Hurn & Mirosevich, 2008). The ANOVA on gain scores and the mixed factorial design approaches were therefore used in this study as the nature of the data satisfied the conditions that would make the results reliable. The histogram showed that the scores on the dependent variable were not normally distributed.

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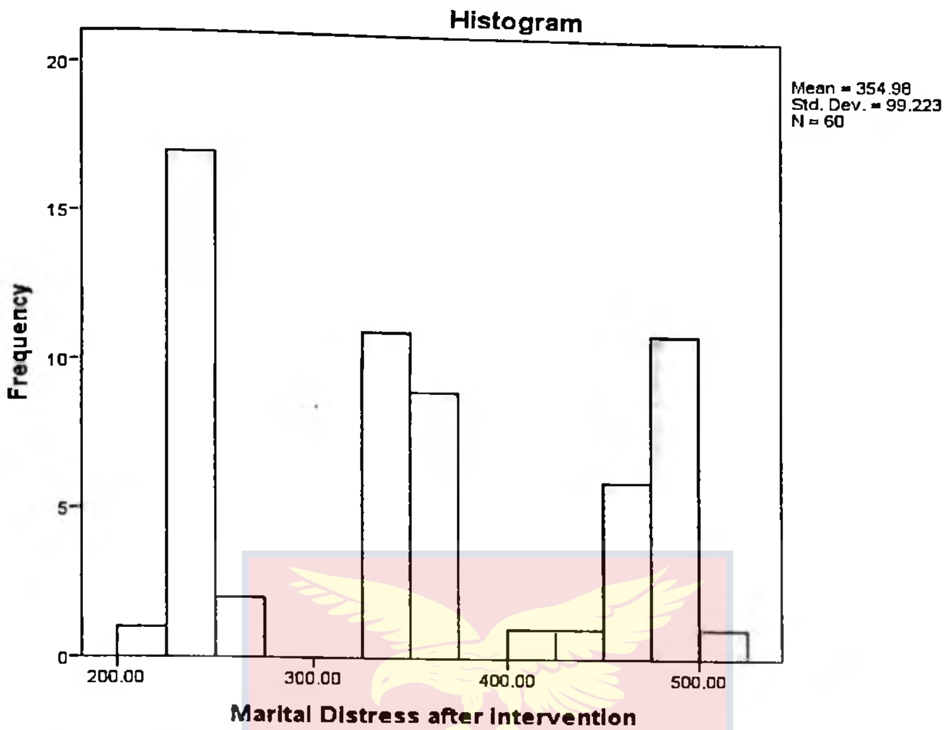

Figure 3- Marital distress after intervention

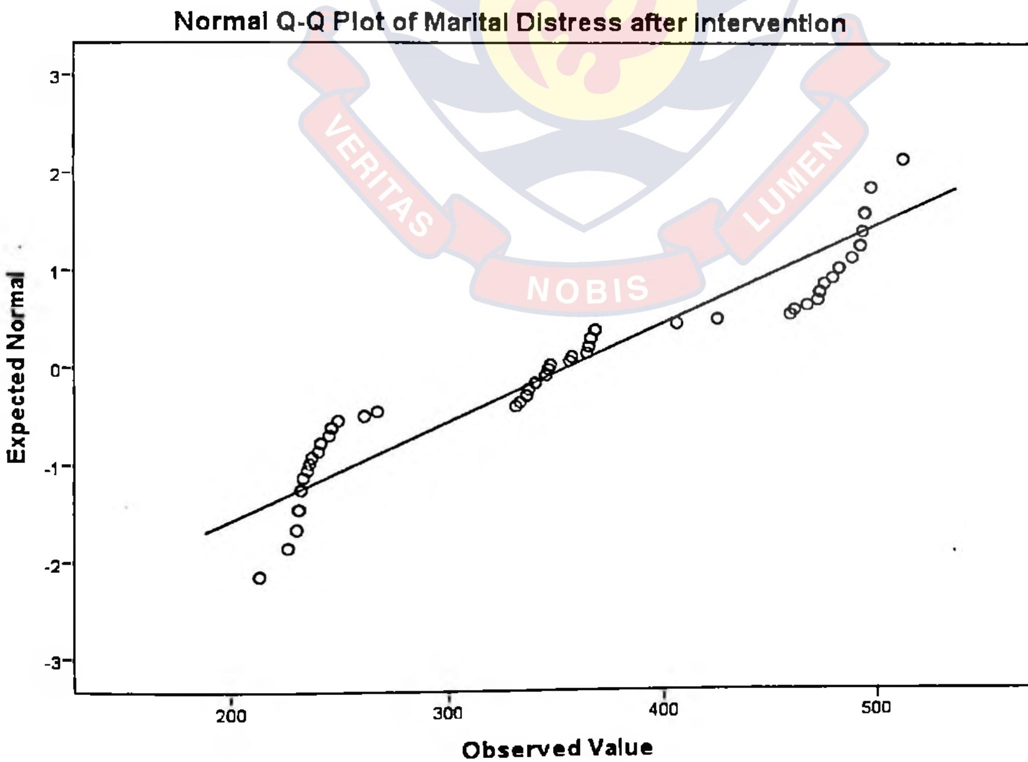

Figure 4- Normality plot

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The normality assumption tests, as presented with the histogram and the Q-Q plot for the outcome measure (the post-intervention distress level), indicated that the scores on the outcome variable did not meet the assumption. The Kolmogorov-Smirnov and Shapiro-Wilk statistics both confirmed the violation of the test of normality of the dependent measure.

Table 5- *Test of Normality of the Outcome Variable*

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Marital Distress after intervention	.157	60	.001	.883	60	.000

a. Lilliefors Significance Correction

Two other critical assumptions that need to be satisfied for ANCOVA, homogeneity of regression slope and linear relationship between the outcome variable and the covariate, analysis were also not satisfied by the data. Figure 4 showed that the regression slopes were not homogenous across the groups and the results in Table 5 also indicated that the linear relationship between the outcome variable (post-intervention) and covariate (pre-intervention) scores was also violated.

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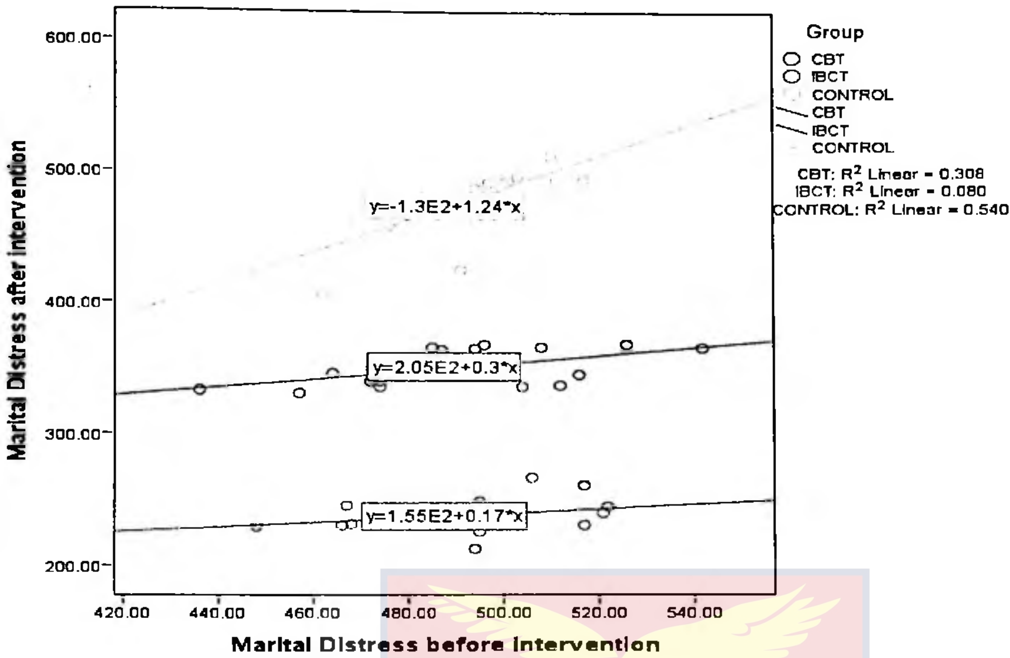

***Figure 5*- Test of linear relationship**

Table 6- *Test of Linear relationship between the outcome variable (Post-intervention) and covariate*

Tests of Between-Subjects Effects					
Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	570716.823[a]	5	114143.365	607.375	.000
Intercept	474.126	1	474.126	2.523	.118
Group	1434.934	2	717.467	3.818	.028
Marital distress	6279.144	1	6279.144	33.412	.000
Group *distress	3365.822	2	1682.911	8.955	.000
Error	10148.160	54	187.929		
Total	8141655.000	60			
Corrected Total	580864.983	59			

a. R Squared = .983 (Adjusted R Squared = .981)
Dependent Variable: Marital Distress after intervention

Hypotheses 1 and 2 were tested with the two-way mixed ANOVA to find out the effectiveness of the interventions in reducing marital distress over time. To test this, the pre-intervention levels of marital distress were compared with the post-intervention distress scores (within-subject), and the differences among the

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experimental conditions (CBT, IBCT and control groups) were also compared (between-subjects) in the two-way mixed ANOVA. The two way mixed design was used because the test involved both within- and between-subjects measures (Mordkoff, 2016). This test has been found to be an accurate model in a balanced (equal group size) repeated measure designs (Shek & Ma, 2011) as was the case in this study. This type of design allows researchers to study both inter and intra-group differences. It also helps to test whether the two sets of scores (pre-test/posttest and experimental groups) were statistically different (Mordkoff, 2016) to be able to tell whether the intervention had been effective. The F-statistics for the interaction between the treatment and the pretest-posttest factor in the test represents the main effect in this test and has been found to be a sound way to analyze pretest-post test data (Dimitrov & Rumrill, 2003; Mordkoff, 2016).

In addition, the analysis of variance (ANOVA) was used because the following assumptions were satisfied:

1. The respondents were randomly assigned to the groups and the groups were also independently and randomly assigned to the experimental conditions
2. The measure on the dependent variable (marital distress) was on an interval basis
3. The variances of the distributions in the populations are equal. This is commonly referred to as the assumption of homogeneity of variance.

Hypothesis 3 tested the effectiveness of the interventions on the seven dimensions or measures of marital distress. The seven dimensions of the marital

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distress were partitioned to test whether the intervention had been effective regarding the various dimensions. To test this, the one-way MANOVA on gain scores of marital distress as the dependent measures for the dimensions. This procedure has been found to be very reliable when the posttest scores and the pretest scores do not have proportional variances (Overall & Woodward, 1995; Rogosa, Brandt & Zimowski, 1982; Zimmerman & Williams, 1982; Dimitrov & Rumrill, 2003; Mordkoff, 2016), which is normally the case in many testing situations, as it was in this study. The MANOVA was used in this case because there were multiple dependent variable (the seven measures of marital distress).

Hypotheses 4, 5 and 6 were tested with the three-way multivariate analysis of variance. This test was done on the pre-intervention levels of marital distress of the respondents because the hypotheses sought to test whether there were sex, age category and length of years in marriage category differences among the respondents. The three independent variables were in categories, and the dependent measures were interval measures. Given that there were seven different dependent measures and three categorical independent measures, the MANOVA was deemed the most appropriate analytical approach. Three different MANOVAs could have been done for the three different categorical independent variables, but the use of the three-MANOVA is superior, because it helps to avoid type 1 error (O'Brien & Kaiser, 1985). The use of MANOVA also enables interactions effects to be assessed. Tests based MANOVA approach are free of sphericity assumptions (O'Brien & Kaiser, 1985) and could easily be done with modern statistical software, such as the SPSS.

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Treatment procedure/activities

The treatment procedure was used for clients who were very severely distressed and those who were severely distressed in their marriages using the marital distress scale adapted for the study. The sixty participants selected were placed in three groups of 20 participants in each group. The first group was subjected to CBT skills and techniques as a way of reducing marital distress. The second group was subjected to IBCT skills and techniques in reducing marital distress while the third group was the control group. The intervention treatment using IBCT and CBT lasted for 12 weeks concurrently. The interventions took place in Pentecost International Worship Centre (PIWC, Cape Coast) from 2:30pm to 3: 30pm for IBCT group. The CBT intervention group started from 4:00pm to 5:00pm. To ensure the truthfulness of the interventions, the researcher was very objective and allowed issues to go on formally without any form of manipulation; the views all the participants were respected.

Treatment procedure for Cognitive Behavioural Therapy (CBT)

This treatment plan focused on the first group of clients who were severely distressed and those who were very severely distressed in their marriages. This group of couples as stated earlier was subjected to CBT skills and techniques as a way of reducing marital distress. According to Halford (2011), CBT is relevant because the simplest reason is that our unique patterns of thinking, feeling and behaving are significant factors in our experiences, both good and bad. Since these patterns have such a significant impact on our experiences, it follows that these patterns can change our experiences. CBT therefore aims to change our thought

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patterns, hold our attitudes and ultimately our behaviour in order to help us face our difficulties and more effectively strive towards our goals (Martin, 2016).

CBT is also seen as a hands-on approach that require the therapist and the client to work together as a team to identify the problems the client is facing, come out with new strategies for addressing them and think up positive solutions (Martin, 2016). According to Chambless and Ollendick (2001), CBT combines both cognitive and behavioural therapies and has a strong empirical support for treating mood and anxiety disorders but the basic premise is that, emotions are difficult to change directly so CBT targets emotions by changing thoughts and behaviours that are contributive to the distressing emotions. For the current study, this intervention which is the counselling phase, covered a period of eight weeks using a minimum of 50 – 60 minutes per session (Martin, 2016).

CBT therefore assist clients to develop the competencies of re-examining their thoughts, identify illogical thoughts and faulty judgments or conclusions and replace them with positive thoughts as a way of reducing distress in their relationships. Group counselling approach was used for all the sessions. All the sessions were characterized by discussion, questions and answers, brainstorming, verbal instructions, demonstration of skills, assignments and presentation of findings.

Report on the CBT Treatment

Session One: The Introductory Session.

The following objectives characterized the first session:

1. Get to know each other and set the goals of the counselling sessions

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2. Outline the roles of the counsellor
3. Outline the roles of the participants
4. Assist the participants to set up the ground rules
5. Assist the group members to state their expectations for counselling
6. Elect group leaders
7. Give an overview of marital distress, the nature of CBT and what counselling entails.

Activities of the First Session

The first session started with welcoming clients and self-introduction, where every client introduced himself/herself and stated how he or she should be called during the counselling interaction. This was followed by setting up the goals for the counselling interaction where participants contributed in setting up the goals for counselling, stated the need to have stress free marriage and enjoy their marriages. My role as a counsellor was spelt out and the role of the participants was also discussed.

The participants also set up the ground rules that should govern the activities/behaviours of members. This includes respecting each other, working with time and tolerating the views of each other. All the group members stated their expectations for the eight week session. Group leaders were also elected. This includes the leader, his assistant, the secretary (a lady) and the organizer. The counsellor gave an overview of what marital distress entails the effects of marital distress. Group members also contributed to the issues of marital distress and shared some experiences. The first session ended with the counsellor giving an overview

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of what CBT entails, especially how our thinking pattern affect our behaviour and produces feelings which causes us to draw certain conclusions that produces distress in our relationships. The participants were also exposed to the filtering, polarised thinking, overgeneralization, selective abstraction, personalization, magnification and minimization among others.

Evaluation of the first session

The group members were very enthused about the activities of the day and pledged their commitment to participate and take every activity very seriously. They wished these kind of activities should be an on-going process as a way of building very strong marital relationships. The participants were also briefed about the skills and techniques used to assist clients in CBT. Cognitive restructuring and the processes involved in cognitive restructuring such as thought stopping, positive self-talk and visualization where all discussed with the participants. Issues about de-indoctrination and re-indoctrination were all discussed.

Session 2: Causes of Marital Conflict

This session discussed how conflicts could lead to marital distress. The following objectives were set for this session:

1. Examine what leads to conflicts in marriage
2. Discuss how conflicts could lead to marital distress
3. Discuss the instrument (Appendix A, Section B) and examine how it could lead to distress in marriage
4. Discuss how to avoid conflicts using cognitive restructuring.

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Activities for the Second Session

The second session starts with welcoming clients and briefly recapitulating what was discussed during the first session. The group proceeded to discuss what causes conflicts in marriage in general and how these conflicts could lead to marital distress. This was followed up by discussing the instrument which is on the causes of marital distress. The group finally discussed how to avoid marital conflict using CBT skills and techniques.

Evaluation of the Second Session

The group members asked series of questions that was discussed by the whole group. This session was very interactive as every member contributed to the discussions. The participants were given an assignment on the nature of marital violence to be discussed at the next meeting.

Session 3: Marital Violence

This session looked at how violence could lead to marital distress

Objectives;

1. Examine what leads to violence in marriages
2. Discuss how violence could lead to marital distress
3. Discuss the instrument (Section C, Appendix C) and discuss how it could lead to marital distress
4. Examine how to avoid violence using the skills and techniques of CBT.

Activities for the Third Session

Clients were welcomed to the third session where everything started with the presentation of the assignment given at the last session. The group then opened

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discussion on the causes of violence in marriage and how violence could lead to marital distress. The Section C of the instrument was discussed and some of the members shared their experiences on violence. The group finally discussed how to avoid violence in marriage using the skills and techniques of CBT.

Evaluation of the Third Session

The group members participated actively in all the discussions of the day and made a lot of valuable contributions. Moments of reflection and cognitive restructuring assisted the group members to avoid the use of violence in their marital relationships.

Session 4 Communication Difficulties

This session discusses how communication difficulties could lead to marital distress. The following objectives were set for this session:

Objectives:

1. Examine what leads to communication problems in marriages
2. Discuss how communication problems could lead to marital distress
3. Examine the Section D of the instrument and discuss how it could lead to marital distress
4. Discuss how to avoid or reduce communication difficulties using skills and techniques of CBT.

Activities of the Fourth Session

Using questions and answers, the counsellor guides participants to examine what leads to communication problems in marriage. The group members also discussed how communication problems could lead to marital distress. The Section

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D of the instrument was examined and members discussed how it could lead to marital distress. The group also discussed how to avoid communication difficulties/challenges using CBT skills and techniques especially cognitive restructuring. Skills training and cognitive restructuring were the key techniques used.

Evaluation of the Fourth Session

The group members raised a number of issues regarding the nature of communication in their marriages and how it has affected the beauty of their marriages. They were however happy to discuss how to avoid communication challenges, and stop reading meaning into every issues in the relationship.

Session 5: Financial Management

This session discusses how monetary issues could lead to marital distress. The following objectives were set for the session:

Objectives:

1. Examine the causes of financial problems/difficulties in marriage
2. Discuss how financial difficulties could lead to marital distress
3. Examine the items in the Section E of the instrument and how it could lead to marital distress and
4. Discuss how to properly manage finances in marriage using CBT skills and techniques.

Activities for the Fifth Session

Participants were made to brainstorm on what causes financial difficulties in relationships. The group also discussed how financial difficulties could produce

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distress in marriages. The group members further examined the items under Section E of the instrument and discussed how it could lead to marital distress. The counsellor finally led the group to discuss how CBT skills and techniques could be used to avoid or reduce marital conflicts. Strategies used includes, skills training, role playing and cognitive restructuring.

Evaluation of the Fifth Session

The group members raised a number of issues such as impulse buying, not preparing any budget and the high cost of living as the major causes of their financial woes. They appreciate the skills training approach and the moment of reflection and cognitive restructuring which was key in all the sessions.

Session 6: Love and Intimacy Concerns

This session discusses how issues of love and intimacy could lead to marital distress. The following objectives were set for the session.

Objectives

1. Examine the causes of love and intimacy challenges in marriage
2. Discuss how love and intimacy concerns could lead to marital distress
3. Examine the items under Section F of the instrument and discuss how it could lead to marital distress.
4. Discuss how to avoid love and intimacy challenges using CBT skills and techniques.

Activities of the Sixth Session

Using questions and answers, the counsellor guided the group members to examine the causes of challenges when it comes to the issue of love, intimacy and

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sex. The members also discussed how love and intimacy concerns could lead to marital distress. The group members also examined the items under the Section G of the instrument and discussed how it could lead to marital distress. The counsellor finally led the group to avoid or reduce marital conflict using skills and techniques of CBT.

Evaluation of the Sixth Session

This session was very interesting as many participants voiced out what is disturbing them in their marriages when it comes to the issue of love and sex. They appreciate the discussions and learnt to apply what they have learnt to better their relationships. Almost everybody made valuable contributions to make the discussion very useful and interesting.

Session 7: Marriage and Stressful Life Events

This session examines how stressful life events could lead to marital distress. The following objectives were set for the session:

1. Examine the causes of stressful life events
2. Discuss how stressful life event could lead to marital distress
3. Examine the items under the Section H of the instrument and how they could lead to marital distress.
4. Discuss how to avoid or mange stressful life events using CBT techniques and skills

Activities of the Seventh Session

The group members were made to brainstorm on the causes of life stressful events and how it could lead to marital distress. This was followed by examining

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the Section H of the instrument and discussing how they could lead to marital distress. Participants also discussed how to avoid life stressful events as a way of reducing marital distress in their marriages using the skills and techniques of CBT. Some stress management techniques such as relaxation, rethinking, reorganizing were also discussed.

Evaluation of the Seventh Session

The group members made valuable contributions to this discussion and how anger could cause them to verbally or physically abuse their spouses. They have also stated how events beyond their control such as death, accidents and illness produced stress in their marriages. They were excited that they will no longer allow certain events to produce distress in their marital relationships.

Session 8: Closing Session

The purpose of this session was to look at the summary of the issues discussed and the actions taken to reduce marital distress among the participants. The following objectives were set for the session.

Objectives

1. Recapitulate the preceding sessions
2. Strategies, skills and techniques discussed
3. Various decisions and actions taking to avoid or reduce marital distress
4. Evaluate the sessions and
5. Completing the instruments for post test.

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Activities carried out at the Last Session

This session started with a review of the issues discussed. This covered the previous sessions as well as the strategies, skills and techniques used and how relevant and helpful they were towards reducing marital distress. The session also discussed the actions taken to reduce marital distress. This involved brainstorming, doing assignments, presenting assignment, skills training, cognitive restructuring and relaxation training. The various decisions taken by the participants were also discussed. The meeting also evaluated the various actions taken throughout the treatment stage and how beneficial and helpful it was to the participants. Also, the challenges encountered were discussed and how to improve upon the sessions in future.

Further, the participants were completed the instrument for posttest analysis. The participants were so enthused and excited to be part of the group counselling and counted themselves blessed. The counsellor was very much grateful to all the participants and showed his deep appreciation for their comportment and contributions during the intervention.

Treatment procedure for IBCT

Introduction

The treatment procedure for the second group of participants who were severely distressed and very severely distressed were subjected to IBCT skills and techniques as a way of reducing marital distress. According to Makhmoor (2017), IBCT provides effective outcome for marital distress because it offers acceptance based techniques to manage troublesome personality differences between spouses.

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According to Christenson (1995), IBCT is an "acceptance and tolerance" based approach which was developed by Christenson and Jacobson as an integrative model of traditional behavioural couple therapy (TBCT) (Jacobson & Christenson, 1995). The TBCT is a problem solving approach which focuses on "behaviour change" of spouses, whereas IBCT stresses that acceptance is the key to satisfactory relationships (Cordova, Jacobson & Christenson, 1998). IBCT incorporates both change and acceptance but in a balanced way (Mairal, 2015).

Makhmoor (2017) further asserts that IBCT is an effective approach used to solve problems of distressed couples who faces adjustment problems due to differences in their personalities. It is therefore hoped that couples who are taken through this therapy will accept and tolerate each other as a way of reducing or avoiding marital distress in their relationships.

Report on the intervention for IBCT

First Session: The Introductory Session

Introduction

The purpose of this meeting was to meet the couples who had been selected to go through IBCT skills and techniques as a way of reducing marital distress. The following objectives were set for this session.

Objectives:

1. Get to know each other through self-introduction
2. Set goals for the counselling session
3. Spell out the role of the counsellor and the roles and expectations of the clients during counselling

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4. Guide the participants to set the group norms that will guide the counselling sessions.
5. Elect group leaders
6. Give an overview of marital distress, the nature of IBCT and the nature of group counselling.

Activities of the first session

The counsellor welcomed all the clients and introduced himself to the group. This was followed by self-introduction, where every group member introduced himself or herself and stated how he or she wished to be called during counselling session. The counsellor then guided the group to set up the goals for the counselling interaction and what the couples hope to achieve at the end of the counselling session. The counsellor spelt out his roles to the group and also discussed the role expected of every member in the group.

The counsellor also guided the group members to set up the ground rules that will govern all the activities of the group. Leaders who will assist the counsellor and the group members in diverse ways were also elected. These are the group leader, the assistant group leader, the secretary and the organizer. The counsellor also gave an overview of what marital distress entails, the causes and effects of marital distress, what IBCT is all about and how it could help in reducing marital distress. Finally, the participants were taken through what group counselling entails and the need to treat the issue discussed confidential.

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Evaluation of the first session

The group members were very happy and saw themselves as fortunate to be part of the group. They hoped their aspiration of the various sessions would be attained and they would have satisfaction and stress-free in their marriages.

Session 2- Marital conflict

The second session discussed how conflicts in marriage could lead to marital distress. The following objectives were set for the second session.

Objectives:

1. Examine the causes of conflicts in marriage
2. Discuss how conflicts could lead to marital distress
3. Discuss the items in the Section B of the instrument and how they could lead to marital distress
4. Examine and discuss how IBCT could help in reducing marital distress.

Activities of the second session

The second session started with the review of the last session. This was followed by a discussion on what causes conflicts in marriage and how this could lead to marital distress. The group, led by the counsellor, also discussed the Section B of the instrument which is about marital conflict. This was followed by a discussion on how IBCT could help the group members to reduce distress in their marriages. The discussion was dominated by brainstorming, self-examination and skills training.

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Evaluation of the second session

The group members self-disclosed issues leading to conflicts in their marriages and appreciated the discussions on using IBCT to resolve conflicts in marriages and also reduce marital distress. They wish this kind of activities should have been carried out in all churches. The session was very interactive as every group member made contributions.

Session 3- Marital violence

The purpose of this session is to examine how violence could lead to marital; distress. The following objectives were set for the session

Objectives;

1. Examine the causes of violence in relationships
2. Discuss how violence could lead to martial distress
3. Discuss the Section C of the instrument and examine how it could lead to marital distress
4. Examine the skills and techniques of IBCT and how it could help in reducing marital distress.

Activities of the third session

This session discussed the causes of violence in marriage, the effects of violence and how violence could lead to marital distress. This was followed by discussing the instrument on violence and how this could lead to marital distress. A further discussion was on how IBCT skills and techniques could help in reducing marital distress. Issues of problem solving, acceptance and tolerance which are key concepts of IBCT were also discussed.

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Evaluation of the third session

This session was very interactive as almost every member contributed to the discussions and made valuable contributions. Some of the group members vow never to resort to violence as a way of solving their marital challenges.

Session 4- Communication difficulties

This session discusses how communication problems could lead to marital distress. The following objectives were set for the session.

Objectives:

1. Examine what leads to communication challenges
2. Discuss how communication challenges could lead to marital distress
3. Examine the items in the Section D of the instrument and discuss how it could lead to marital distress
4. Using IBCT skills and techniques to reduce communication challenges as a way of reducing marital distress.

Activities of the fourth session

Through the use of questions and answers, group members were made to brainstorm and come out with the causes of communication problems in marriages and how it affects the beauty of the relationship. The counsellor then led the group to discuss the Section D of the instrument and how it could lead to marital distress. This was followed up by using the skills and techniques of IBCT to see it could reduce marital distress among married couples.

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Evaluation of the fourth session

The group members see communication challenges in relationships as a major cause of distress in their relationships. Most of the members lamented on the harsh and impolite ways their spouses used to talk to them. Some members self-disclose how they were physically assaulted because of communication problems.

Session 5- Financial difficulties

This session discusses how financial problems could lead to marital distress. The following objectives sere set up for the session.

Objectives:

1. Examine the causes of financial problems in marriage
2. Discuss how financial challenges could lead to marital distress.
3. Examine the items in the Section E of the instrument and discuss how they could lead to marital distress.
4. Discuss how to avoid or reduce marital distress using IBCT skills and techniques.

Activities of the fifth session

The counsellor guides the group members to discuss the causes of financial problems and how financial problems could lead to marital distress. The counsellor also led the group to discuss the items under Section F of the instrument and how it could lead to marital distress. The counsellor further led the group to discuss how IBCT techniques such as empathic joining and detachment from the problem could assist the participants to reduce marital distress.

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Evaluation of the fifth session

The group members appreciated the techniques and skills of IBCT in reducing marital distress. Some of the participants stated that if they had knowledge of IBCT skills and techniques, they would not have experienced distress in their marriages. They were therefore very much happy to learn more about IBCT techniques.

Session 6- Love and intimacy concerns

The sixth session discusses how love and intimacy challenges or difficulties could lead to marital distress. The following objectives were set for the session.

Objectives:

1. Examine the causes of love and intimacy problems in marriage
2. Discuss how love and intimacy problems could lead to marital distress
3. Examine the items under the Section F of the instrument and discuss how it could lead to marital distress
4. Discuss how to solve love and intimacy challenges as a way of reducing marital distress using skills and techniques of IBCT.

Activities of the sixth session

The counsellor asked the group members to brainstorm and come out with the causes of love and intimacy difficulties and how they could contribute to marital distress. The counsellor also led the group to examine the Section F of the instrument and discuss how the items could lead to love and intimacy difficulties thereby producing distress in the relationship. This section was concluded by discussing how IBCT technique such as tolerance building, respecting the

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differences of your spouse and communicating effectively could solve marital distress.

Evaluating the sixth session

The sixth session was characterized with a lot of self-disclosures that points to the fact that many couples were going through sexual challenges in their marriage. The participants, however, appreciated the skills and techniques of IBCT especially how effective communication is missing in their relationships, hence, the difficulty they go through in taking meaningful sexual decisions. This session was very interactive and the participants showed gratitude to the counsellor.

Session 7 Marriage and stressful life events

This session discusses how stressful life events could lead to marital distress. The following objectives were set for the session:

Objectives

1. Examine the causes of life stressful events
2. Discuss how life stressful events could lead to marital distress
3. Examine the items under the Section G of the instrument and how they could lead to marital distress
4. Discuss how to reduce or avoid marital distress with the help of IBCT techniques and skills.

Activities of the seventh session

The counsellor led the group to come out with the causes of life stressful events and how they could lead to marital distress. This was followed by discussing the items under the Section G of the instrument and discussing how they could lead to

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marital distress. This section ended with discussions on how to reduce or manage life stressful events as a way of reducing marital distress using skills and strategies of IBCT especially "detachment from the problem"

Evaluation of the seventh session

This session was also very interactive as the participants raised some issues that gave them stress in their relationship. Some participants said they were really enlightened and this would bring a lot of changes in their marriages. They also agreed that they would no longer allow certain events occurring to produce stress in their marriages

Session 8- Closing session

The purpose of this session was to review the whole sessions and look at the major decisions taken. The following objectives were set for the last session:

1. Give a brief summary of the various sessions
2. Evaluate the activities of the whole counselling encounter
3. Completing the instrument for post-test.

Activities of the last session

The counsellor guided the participants to discuss the activities carried out from the beginning to the end of the counselling interaction. The participants were also assisted to discuss the various actions taken to reduce marital distress. The skills and techniques of IBCT were examined and how helpful they were in assisting the participants to reduce stress in their marriages. This session also encouraged the participants to evaluate the entire sessions, talk about the progress made and the challenges encountered during the sessions. The participants also fill the

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questionnaire for the post-test analysis of the study. The session was terminated with a word of gratitude and appreciation to all the participants. The participants were also grateful to the counsellor for assisting them to learn and make adjustments in their marriages.

Administration of the posttest instrument to the control group

This activity was carried out after the counselling sessions with the treatment groups using IBCT and CBT respectively. I had a meeting with the control group where I brief them about the exercise and gave them the instrument to fill for the post test. The completed instrument was collected for data analysis.

Counselling the control group

The control group is the group that was held constant and did not benefit from the intervention. However, the control group was given a form of intervention after completing the posttest instrument. According to Gall, Borg and Gall (1996), this group should also be given a form of intervention as a way of assisting them through the challenges they face. In all, four intervention meetings were organized for the control group using CBT skills and IBCT skills in managing marital distress. Although this was not carried out into detail as done for the treatment groups, the participants were enthused and declared their appreciation for the four sessions held. Some of the participants also requested for further counselling in order to straighten up some issues in their marriages. Some participants also requested for individual counselling and the researcher was able to meet them and gave them further assistance.

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Data management

In order to execute good data management practices, the researcher solely handled the completed questionnaires to ensure that information given out by participants does not end up in wrong hands due to the sensitive nature of the study. When the data was collected, it was securely stored in the researcher's office cabinet and locked to prevent other people from having access to it. Also, the data entered in the computer was protected with a password. Respondents were allowed to write their names on the instrument. This anonymity also helped to protect the respondents. To maintain the integrity of the study and the University of Cape Coast, the researcher ensured that accurate data was used so that results could be verified and data reused in future. Also, interactions held during the intervention were treated as strictly confidential. Further, the views of every participant was respected, there was no form of manipulation in terms of age, gender and length of years in marriage. These were ensured as a way of controlling extraneous variables that could have affected the internal validity of the result. The random assignment of the participants into the three different groups also assisted in controlling for extraneous variables; this eventually increased the internal validity of the results.

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CHAPTER FOUR

RESULTS AND DISCUSSION

Overview

This chapter focuses on the results and discussion of the data collected for the study. The purpose of this study was to ascertain whether using Integrated Behavioural Couples Therapy and Cognitive Behavioural Therapy as intervention strategies could reduce marital distress among Pentecost Christian couples in Ghana. The study was carried out using the pre-test, post-test control group design, a type of quasi-experimental research. The study made use of an initial sample of 200 participants constituting married couples. Out of this, the researcher sampled 60 participants who were severely distressed using a compendium of instrument on Conceptualising and Measuring "Healthy Marriages" for Empirical Research and Evaluation Studies (Task One Part II), developed by Carrano, Cleveland, Bronte-Tinkew and Moore (2003). This chapter presented the responses of the participants and how they are analysed. Data analysis comprises the demographic characteristics of the respondents as well as analysis of the main data.

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Demographic Characteristics of the Participants

This section presents the demographic characteristics of the participants. The demographic variables examined were gender, age and length of years in marriage. The rationale for selecting this was to understand the dynamics of respondents' demographic characteristics and how they are linked with marital distress or how they influence marital distress. Tables 7-9 present results on the demographic characteristics of the participants.

Table 7- *Gender of Respondents*

Gender	Frequency	Percentage (%)
Male	30	50
Female	30	50
Total	60	100.0

The results in Table 7 revealed that there were equal number of males (30 or 50%) and females (30 or 50%).

Table 8- *Age of Respondents*

Age (Years)	Frequency	Percentage (%)
21-30	13	21.7
31-40	31	51.7
41-50	8	13.3
51-60	8	13.3
Total	60	100.0

The results in Table 8 revealed that majority of the respondents (31 or 51.7%) were between the ages of 31-40 years. An appreciable number of them (13

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or 21.7%) were between the ages of 20-30 years. Furthermore, eight (8 or 13.3%) were from the age brackets 41-50 years and 51-60 years

Table 9- *Distribution of Respondents by Length of years in Marriage*

Length of Marriage (Years)	Frequency	Percentage (%)
1-5	26	43.3
6-10	21	35.0
11-15	4	6.7
16-20	2	3.3
21-25	3	5.0
25-30	4	6.7
Total	60	100.0

The results in Table 9 revealed that majority of the participants (26 or 43.3%) had been married for 1-5 years, (21 or 35.0%) of them were married for 6-10 years. The same number of them (4 or 6.7%) had been married for either were 11-15 years or 25-30 years. The results further revealed that three (or 5.0%) of the participants had been married for a period of 21- 25 years, while only two (or 3.3%) had been married for a period of 16-20 years.

Analysis of Main Data

The study involved three experimental conditions: (1) participants exposed to CBT intervention, (2) Participants exposed to IBCT intervention and (3) control group. The 60 participants selected after the screening were randomly assigned to these experimental conditions, with each experimental condition having 20 participants. The pre-test levels of distress of the participants in the experimental

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conditions were assessed to ensure that the levels of distress were equivalent among all the groups before the intervention. Table 4 presents the pre-test means and standard deviations. The mean of the three groups (Table 10) were largely equivalent: CBT (490.50), IBCT (492.30) and control (490.98). Billson (2014) maintains that it is essential to conduct a test of equivalent in an experimental study. He noted further that result of such a test should reveal that the control and experimental groups are equivalent.

Table 10- *Test of Equivalence among Treatment and Control Groups*

	N	Mean	SD	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
CBT	20	490.50	24.84	5.55	478.88	502.12	436.00	542.00
IBCT	20	492.30	20.00	4.47	482.94	501.66	448.00	522.00
CONTROL	20	490.15	14.66	3.28	483.29	497.01	462.00	517.00
Total	60	490.98	19.94	2.57	485.83	496.13	436.00	542.00

A one-way between groups Analysis of Variance (ANOVA) was conducted to test the equivalence of the marital distress levels of the groups before the interventions. The Levene's test indicated that there was homogeneity of variance among the groups [$F(2, 57) = 1.739$, $p = .185$]. The results showed that the mean scores on the level of marital distress of the three groups were not significantly different ($F_{(2, 57)} = .065$, $p = .937$). Thus, the level of marital distress of the treatment groups and the control group was equivalent as shown in Table 11.

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Table 11- *ANOVA comparing the pre-intervention Marital Distress means for CBT, IBCT and Control groups*

	Sum of Squares	df	Mean Squares	F	Sig.
Between Groups	53.233	2	26.617	.065	.937
Within Groups	23405.750	57	410.627		
Total	23458.983	59			

This provided grounds for the intervention to be done to ascertain the efficacy of the two therapies in reducing marital distress. Graham (2011) argues that for experimental research, three assumptions must be met. These are; the groups should be equivalent, homogeneity of variance among the group and fidelity of the researcher. From the results above, all these conditions were met. For fidelity, the researcher has considerable knowledge in experimental conditions and is a practicing counsellor.

Hypotheses Testing

This section presents results of the study in terms of hypotheses.

Hypotheses 1and 2

H_0 1: There is no significant difference in the effect of the interventions (CBT and IBCT) on marital distress among couples in the Cape Coast Metropolis.

H_1 1: There is a significant difference in the effect of the interventions (CBT and IBCT) on marital distress among couples in the Cape Coast Metropolis

$H_0$2: There is no significant difference in the effectiveness of IBCT in reducing marital distress among married couples as compared to CBT.

H_1 2: There is a significant difference in the effectiveness of IBCT in reducing marital distress among married couples as compared to CBT.

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These hypotheses tested whether the CBT and IBCT therapies had been effective in reducing the level of marital distress among the participants, and whether IBCT has been more effective than CBT. The mean scores on the level of marital distress among participants exposed to the two therapies were therefore compared with those in the control group who did not receive any intervention. Table 12 presents the means and standard deviations of the CBT, IBCT and control groups for the pre-test and post-test overall marital distress scores.

Table 12- *Descriptive Statistics*

Measure	Group	Mean	Std. Deviation
Marital Distress before intervention	CBT	490.50	24.84
	IBCT	492.30	20.00
	CONTROL	490.15	14.66
	Total	490.98	19.94
Marital Distress after intervention	CBT	350.55	13.32
	IBCT	238.60	11.98
	CONTROL	475.80	24.65
	Total	354.98	99.22

Source: Field work (2017)

The results in Table 12 showed that the pre-intervention scores were higher than the post-intervention marital distress scores for all the groups. The pre-intervention score were basically around the same figure, but there were noticeable variations among the post intervention score among the groups. The post-intervention mean for CBT (M = 350.55, SD = 13.32) was higher than that of IBCT (M = 238.60, SD = 11.98), with the level of distress for the control group still high, but slightly lower than the pre-intervention score. High scores on the measurement means marital distress level is high while low score means lower level of marital distress.

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The two-way mixed ANOVA was used to find out whether the interventions had been effective in reducing marital distress, and which of the two interventions (CBT or IBCT) was more effective. Given that the within-group variable (pre-test, post-test) has only two levels and there was only one dependent variable, the box test of equality of variance, Mauchly's test of sphericity and the multivariate tests were not examined.

The test of within-subjects effect (Appendix D-1) indicated that the post-intervention marital distress scores were significantly lower than pre-intervention with very high effect size [F (1, 57) = 2956.50, p < .001, partial eta square = .981]. There was significant interaction effect between the experimental conditions and type of test (pre-test/post-test) [F (2, 57) = 763.73, p < .001, partial eta square = .964], which means that the experimental groups also differed significantly between the pre and post-test periods.

The between-subjects effects analysis tests whether the experimental groups were significantly different. An important assumption for conducting a between-participant ANOVA is that of homogeneity of variance. The Levene's test of equality of error variance (Table 13) indicated that error variance of the dependent variable is equal across the groups as the p-values for both pre-intervention and post-intervention marital distress were greater than .05. This suggests that the assumption of homogeneity of variance has been satisfied. The test of between-subjects effects was then examined.

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Table 13- *Levene's Test of Equality of Error Variances*

	F	df1	df2	Sig.
Marital Distress before intervention	1.739	2	57	.185
Marital Distress after intervention	2.706	2	57	.075

The result of the test of between-subjects effects (Table 14) showed that there was overall main effect of the therapy (Group) on the reduction of marital distress [$F_{(2, 57)} = 259.79$, $p < .001$, partial eta square = .901]. This suggests that at least, two of the groups were significantly different.

Table 14- *Tests of Between-Subjects Effects of Marital Distress*

Source	Type III Sum of Squares	df	Mean Squares	F	Sig.	Eta Squared
Intercept	21469788.03	1	21469788.03	40329.02	.000	.999
Group	276605.117	2	138302.55	259.79	.000	.901
Error	30344.850	57	532.366			

Given that the groups were equivalent at the start of the study, any significant difference between the any of the groups could logically and empirically be attributed to the intervention. The pairwise comparison for simple effects (Table 15) indicate that the mean distress level of the CBT group was significantly higher than that of the IBCT group (mean difference = 55.08, $p < .001$), but lower than the control group (mean difference = 62.45, $p < .001$). The IBCT group mean was also significantly lower than the control group (mean difference = 117.53, $p < .001$). This suggests that both CBT and IBCT have been effective in the reduction of marital distress, but IBCT had been more effective than CBT. Thus, the alternate hypothesis 2 has been supported.

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Table 15- *Pairwise Comparisons the mean scores of CBT, IBCT and Control groups*

(I) Group	(J) Group	Mean Difference (I-J)	Std. Error	Sig.[b]	95% Confidence Interval for Difference[b]	
					Lower Bound	Upper Bound
CBT	IBCT	55.075*	5.159	.000	42.349	67.801
	CTL	-62.450*	5.159	.000	-75.176	-49.724
IBCT	CBT	-55.075*	5.159	.000	-67.801	-42.349
	CTL	-117.525*	5.159	.000	-130.251	-104.799
CTL	CBT	62.450*	5.159	.000	49.724	75.176
	IBCT	117.525*	5.159	.000	104.799	130.251

Based on estimated marginal means
*. The mean difference is significant at the .05 alpha level.
b. Adjustment for multiple comparisons: Bonferroni.

The results further indicated that the post-intervention level of marital distress was significantly lower than the pre-intervention marital distress level (Table 16). The results thus, suggest that the IBCT and CBT were effective in the reduction of marital distress among Christian couples in the Cape Coast Metropolis.

Table 16- *Pairwise comparison of pre-intervention and post-intervention mean marital distress scores*

(I) Test	(J) Test	Mean Difference (I-J)	Std. Error	Sig.[b]	95% Confidence Interval for Difference[b]	
					Lower Bound	Upper Bound
1	2	136.000*	2.501	.000	130.991	141.009
2	1	-136.000*	2.501	.000	-141.009	-130.991

Based on estimated marginal means
**. The mean difference is significant at the .05 alpha level*
b. Adjustment for multiple comparisons: Bonferroni

Given that the interaction effect of the analysis was significant, the simple effects were observed to find out where the interaction took place. Table 17 shows the means of the interaction of the pre-test/post-test and the experimental groups. The results showed marked differences between pre-test and post-test distress

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levels of CBT (139.95) and IBCT (253.70) groups, with a marginal drop in the pre-test and post-test means of the control groups (14.35).

Table 17- Interaction of Therapy and pretest-posttest

Group	Test	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
CBT	Pre-test	490.500	4.531	481.427	499.573
	Post-test	350.550	3.933	342.674	358.426
IBCT	Pre-test	492.300	4.531	483.227	501.373
	Post-test	238.600	3.933	230.724	246.476
CTRL	Pre-test	490.150	4.531	481.077	499.223
	Post-test	475.800	3.933	467.924	483.676

Table 18 shows the simple effects analysis results of differences in mean marital distress between pre-intervention and post-intervention for all the experimental groups. The results indicated that all the differences were statistically significant, including the difference in the control group. Thus, the results therefore suggests that, even though the therapies have proven to be effective in reducing marital distress, the distress levels of the control group has also reduced significantly between the pre-intervention and post intervention assessments. This means that, merely taking part in the study has sensitized the participants and resulted in marginal but statistically significant reduction in their level of distress of the control group, even though they did not undergo any therapy.

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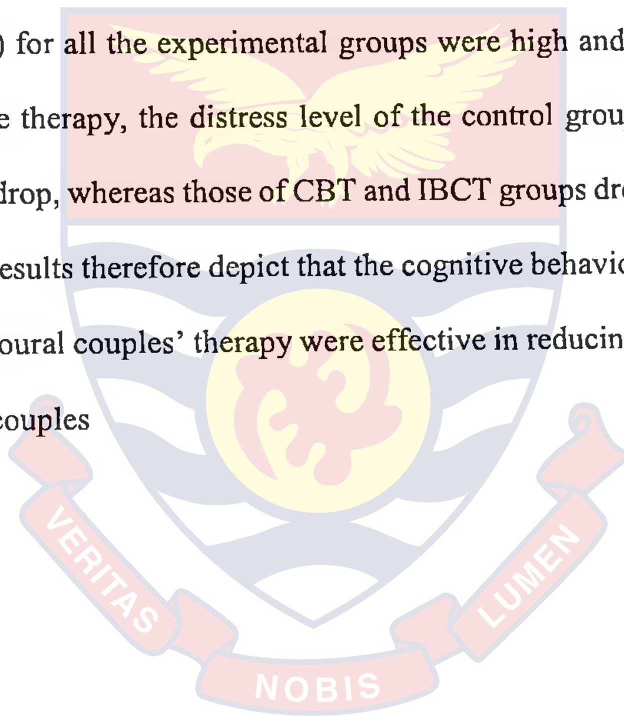
Table 18- *Test of simple effect of marital distress means between pre-intervention and post-intervention for CBT, IBCT and Control Groups*

Source of Variation	SS	df	MS	F	Sig
WITHIN+RESIDUAL	10697.85	57	187.68		
MWITHIN GROUP (1) BY TESTCAT	195860.03	1	195860.03	1043.58	.000
MWITHIN GROUP (2) BY TESTCAT	643636.90	1	643636.90	3429.41	.000
MWITHIN GROUP (3) BY TESTCAT	2059.23	1	2059.23	10.97	.002

(1) = CBT group; (2) = IBCT group; (3) Control group
TESTCAT = Test category (Pretest, post-test)

The profile plot (Fig. 6) clearly depicts that the pre-intervention levels of distress (blue line) for all the experimental groups were high and basically equal. However, after the therapy, the distress level of the control group remained high with only a slight drop, whereas those of CBT and IBCT groups dropped drastically (green line). The results therefore depict that the cognitive behavioural therapy and integrative behavioural couples' therapy were effective in reducing marital distress among Christian couples



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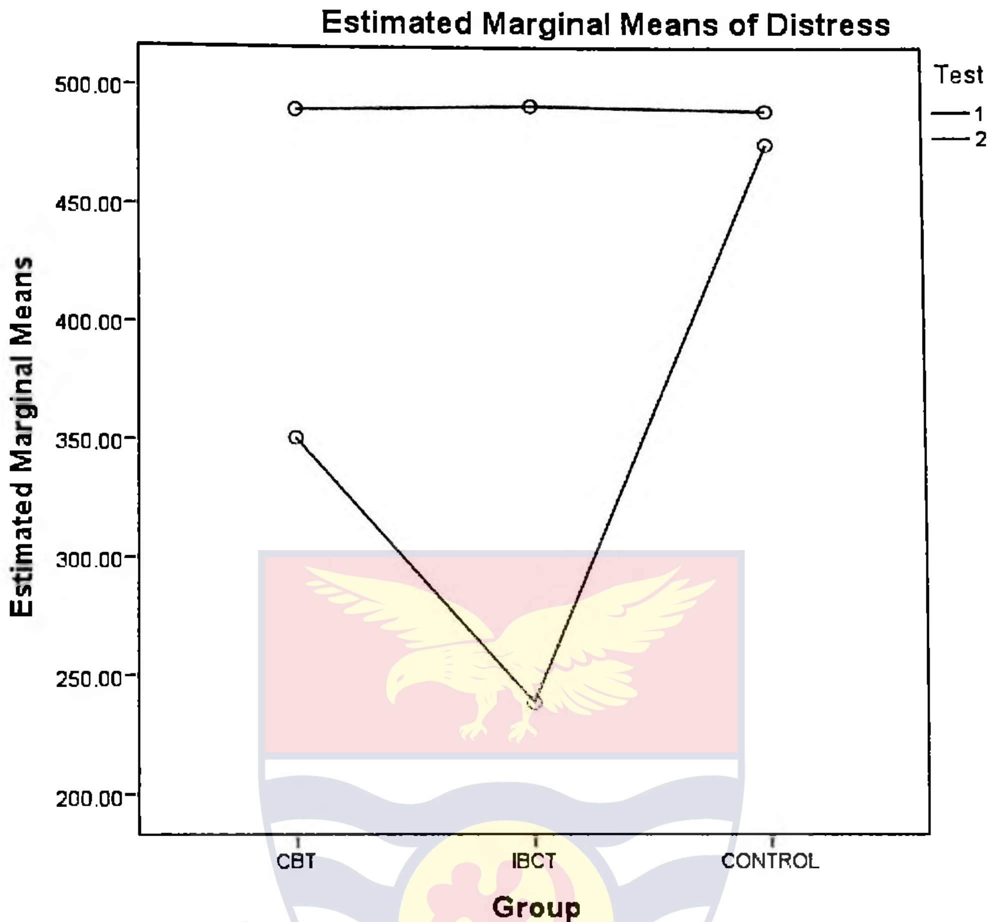

Figure 6- **Post and pre intervention marital distress plot**

Hypothesis 3

Test of effects of IBCT and CBT on the dimensions of marital distress

H_0 3: There is no significant difference in the effects of the interventions on the various dimensions of marital distress

H_1 3: There is significant difference in the effects of the interventions on the various dimensions of marital distress

Having observed significant effectiveness of the therapies on overall marital distress, the one-way between-groups MANOVA analysis was done, using the *difference on gain score procedure* to test the significance of the differences among

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the CBT, IBCT and control groups (between groups) of the dimensions of marital distress. In this procedure, the difference between the pre-test scores and post-test scores was used as the dependent measure (as explained in the justification of choice of statistical tool in chapter three). The means of the dimensions of marital distress presented in (Appendix D-2) shows that the pre-intervention scores for all the dimensions were higher than those of the post-test intervention scores, except for the control group that the differences were very minimal.

Table 19- *Multivariate Tests of Marital Distress*

	Effect	Value	F	Hyp df	Error df	Sig.	Partial eta Sqd
Intercept	Pillai's Trace	.987	573.253[b]	7.0	51.0	.000	.987
	Wilks' Lambda	.013	573.253[b]	7.0	51.0	.000	.987
	Hotelling's Trace	78.682	573.253[b]	7.0	51.0	.000	.987
	Roy's Largest Root	78.682	573.253[b]	7.0	51.0	.000	.987
Group	Pillai's Trace	1.476	20.936	14.0	104.0	.000	.738
	Wilks' Lambda	.012	59.440[b]	14.0	102.0	.000	.891
	Hotelling's Trace	41.934	149.765	14.0	100.0	.000	.954
	Roy's Largest Root	40.934	304.081[c]	7.0	52.00	.000	.976

The MANOVA multivariate tests (Table 19) showed significant differences for the experimental groups [Pillai's Trace = 1.476, F (14, 104) = 20.936, $p < .001$, partial eta square = .738]. The Pillai's trace statistics was observed because the box's M test of equality of covariance matrices shows that the covariances of the scores were not equal across the groups (Box's M = 118.136, $p < .001$).

Having observed a significant main effect of the interventions, the between-subjects effects were examined to determine which of the marital distress dimensions showed significant differences among the experimental groups (therapies) and the control group.

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Table 20- *Levene's Test of Equality of Error Variances*

	F	df1	df2	Sig.
Dif_Conflict	1.445	2	57	.244
Dif_Violence	1.090	2	57	.343
Dif_PersonalCom	1.544	2	57	.201
Dif_JoinCom	.920	2	57	.404
Dif_FinMgt	.175	2	57	.840
Dif_Intimacy	1.364	2	57	.264
Dif_Stress	1.243	2	57	.280

The Levene's test in Table 20 showed that the error variance was equivalent or equal across the groups.

The test of between-subject effects (Appendix D-3) showed that there were significant differences among the experimental groups for all the dimensions with the exception of financial management difficulties [$F(2, 57) = 2.115$, $p = .130$, partial eta square = .069]. The post-test scores were significantly lower than the pre-test scores across all the dimensions, except financial management challenges. This means that the intervention has generally been effective.

The pairwise comparison (Appendix D-4) of marital distress scores for the groups that were exposed to the IBCT were significantly lower than those exposed to CBT and the control group for all the dimensions, except financial management difficulties where there were no differences between the experimental conditions. Take for example marital conflict scores, the mean score for the IBCT group was significantly lower than the CBT group (mean difference = 12.25, $p < .001$). The level of marital conflict for the control group was significantly higher than the CBT group (12.05, $p < .001$) and IBCT (24.30, $p < .001$). This means that the intervention with both CBT and IBCT had been effective in reducing marital conflict among

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couple, with IBCT being more effective than CBT in helping Christian couples with marital distress.

Hypothesis 4

H_0 4: There is no significant difference in marital distress with regard to gender

H_1 4: There is a significant difference in marital distress with regard to gender

This was done using the pre-intervention distress scores. The multivariate analysis of variance (MANOVA) was used to test this. The multivariate test results (Appendix D-5) showed that the level of marital distress among the respondents did not differ based on gender (wilk's lambda = .730, F (8, 35) = 1.62, p =.156).

Hypothesis 5

H_0 5: There is no significant difference in marital distress with regard to age of the participants.

H_1 5: There is a significant difference in marital distress with regard to age of the participants.

Multivariate analysis of variance (MANOVA) was used to test this hypothesis. The multivariate test results (Appendix D-5) showed that the level of marital distress among the respondents did not differ based on their age (wilk's lambda = .498, F (24, 102.11) = 1.158, p =.129).

Hypothesis 6

H_0 6: There is no statistically significant difference in marital distress with regard to length of marriage

H_1 6: There is a statistically significant difference in marital distress with regard to length of marriage

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Using the pre-intervention distress scores of the respondents, a multivariate analysis of variance (MANOVA) was conducted to ascertain whether marital distress differ in terms of length of years in marriage among the respondents. The multivariate test results (Appendix D-5) showed that the level of marital distress among the respondents did not differ based on length of marriage (Wilk's lambda = .304, $F(40, 155.36) = 1.219$, $p = .197$).

Summary of Results

1. The interventions based on the CBT and IBCT therapies were found to be effective in reducing marital distress among Christian couples in the Cape Coast Metropolis.
2. The IBCT was found to be more effective than CBT in the treatment of marital distress.
3. The therapies were effective for the various dimensions of marital distress. However it was not effective in dealing with financial management challenges and difficulties.
4. The level of marital distress of the respondents in the Cape Coast metropolis did not differ based on age.
5. The level of marital distress of the respondents in the Cape Coast metropolis did not differ based on gender.
6. The level of marital distress of the respondents in the Cape Coast metropolis did not differ based on length of years in marriage.

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Discussions

This section discusses the results of the study. The results are discussed in the order of the hypotheses.

Effectiveness of CBT and IBCT (Hypothesis 1)

This hypothesis tested the efficacies of CBT and IBCT in reducing marital distress. Results of the study indicated that both CBT and IBCT are effective in reducing marital distress. This shows that distressed couples (participants) who were exposed to the two therapies (CBT and IBCT) had a reduction in their marital distresses. In view of this finding, the null hypothesis (H_0) of Hypothesis 1 which states that there will be no significant impact of the two therapies (CBT and IBCT) was rejected in favour of the alternate hypothesis (H_1). This implies that distressed Christian couples who were exposed to the two therapies experienced a reduction in their marital distress; this went a long way to promoting marital satisfaction among the couples in their marital endeavours.

The findings of the current study corroborated with the findings of Ansah (2011) who found only CBT to be effective in improving the marital quality of married people who went through premarital counselling even though he made use of IBCT as well. Ansah holds the opinion that fragmented mind of couples were the results of non-professional counsellors who had taken these married individuals through counselling. The CBT, therefore, helps in pulling the minds of the married people together and shaping their thought patterns. IBCT which dealt with the behaviour patterns of the couples was found less effective as compared to CBT. Ansah explains that behaviour is the outward show of our inner feelings and

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thoughts. If the thoughts are whole then a sound behaviour is shown but if the thoughts are flawed then delinquent behaviour is expected.

The findings of this study are, however, in contrast with Asase-Gyima (2014) who found CBT to be ineffective in improving the marital quality of divorcees. He found that after treatment, only 1 out of the 7 couples he treated desired to remarry their divorced spouses. What Asase-Gyima's study failed to do was to bring to bear reasons that accounted for his findings. The researcher strongly believe that fidelity on the part of the therapist might have accounted for this finding coupled with other challenges such as the length of the intervention convenience of the experimental setting. It was revealed that his study lasted for two weeks. Morrison (2013) suggests that a minimum of 16 weeks is ideal in treating divorcees.

The current study also found both therapies to be effective in improving marital distress. This could be explained by the fact that change and acceptance were worked on using the IBCT while mental traits of the couples were also worked on using the CBT. The intervention lasted for a relatively longer period of time as proposed by Morrison (2013). Again, the finding of the study was not surprising as the pre-intervention the researcher had with the couples revealed that most of the couples needed acceptance and change which IBCT offered. Again, the researcher found among the participants that there were some misconceptions and irrational thoughts the participants were holding onto. For instance some had the mind-set that no one can ever be happy in marriage. Some also had the idea that one can get in and out of marriage any time one wants. These thoughts were erroneous and

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therefore there was the need to reconstruct their thoughts. The CBT did that effectively.

The current study shows that Cognitive Behavioural Therapy (CBT) was effective in reducing marital distress among married couples. The results of this study is consistent with the findings of several other studies (Boostanipoor, Sanayi Zaker, & Kiamanesh, 2007; Cho et al, 2008; Hafezi-Kan & Ghadami, 2011). Boostanipoor et al found that 17% of women experiencing dissatisfactory marriages and were treated with cognitive behavioural marital therapy have shown more improvement in their level of satisfaction. In furtherance, a study by Cho et al. (2008) showed that Cognitive Behavioural Therapy (CBT) is effective in reducing automatic negative thoughts, dissatisfaction with mutual relationships and overall marital dissatisfaction. This implies that many women may rush to draw conclusions that might not be true or accept their own judgement and interpretations about whatever that is happening in their marital relationship. And when this happens, they need to be taken through cognitive restructuring to straighten up thoughts.

Furthermore, the findings of the present study revealed that Cognitive Behavioural Therapy (CBT) was an effective therapy in reducing marital distress among couples. This finding also corroborated with Salarifar (2014 as cited in Ammari, Amini, & Rahman, 2016), who found that Cognitive Behavioural Therapy (CBT) had significant effects on increasing marital satisfaction of marital couples; hence decreasing marital distress among the couples. Salarifar's study dealt with

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designing cognitive-behavioural couple therapy and comparing its effectiveness with increasing couple marital satisfaction.

The findings of this study were also consistent with the findings of Amani (2012) who found that Focused Couple Therapy, CBT and Integrated Emotional-Cognitive-Behavioural therapies caused an increase in marital satisfaction and reduced marital depression among women. Amani compared the effectiveness of three therapies regarding the changes in marital satisfaction and depression in Hamadan women. He found out that all the three therapies helped to increase marital satisfaction and reduced the depression in women.

Again, the findings of the study were also in line with Dillon, (2005) who found that Cognitive-Behavioural Therapy was effective in increasing the compatibility, decreasing marital distress and increasing marital satisfaction of young married women. Amani (2012) in a study compared the effectiveness of emotionally focused couple therapy, CBT and integrated emotional-cognitive-behavioural therapies regarding the changes in marital satisfaction and depression in Hamadan women. He found out that all the three methods helped to increase marital satisfaction and reducing the depression in women. This is a further indication of the efficacy of CBT in handling marital distress.

It was evident in the findings of this study that Integrated Behavioural Couple Therapy (IBCT) helped in reducing marital distress among Christian couples. This finding concured with the findings of several authors (Jacobson et al., 2000; Christensen et al, 2004; Christensen et al., 2010). The findings of the aforementioned authors indicated an improved marital satisfaction (reduction in

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marital distress) in couples that received IBCT, confirming IBCT as a promising therapy. Thus, IBCT as an effective approach is used to solve the problems of distressed couples who face adjustment problems due to differences in their personalities.

Again, the current study was consistent with another study conducted by Mairal (2015) who found that the most important supportive element of IBCT is its acceptance-based techniques that are applied to manage the unresolved problems or the differences that seem uncompromising at some point in life. According to Mairal (2015), IBCT works through three important features: conceptualization, which is based on thematic analysis of a couple's problem, such as closeness versus distance; process polarization, which focuses on emotional acceptance in order to make a change; and identification of mutual trap, in which partners feel stuck and are unable to resolve their issues.

Effectiveness of IBCT over CBT (Hypothesis 2)

This hypothesis tested the efficacy of IBCT over CBT in reducing marital distress. Results of the study indicated the effectiveness of IBCT over CBT in reducing marital distress. This shows that IBCT was more effective in reducing marital distress as compared to CBT among participants. In view of this finding, the null hypothesis (H_0) of Hypothesis 2 which states that there will be no significant impact of IBCT over CBT was rejected in favour of the alternate hypothesis (H_1). This implies that distressed couples who were exposed to IBCT experienced a more effective reduction in marital distress as compared to participants who were exposed to the CBT.

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This finding is in line with the finding of Chilemba (2012) who found in Tanzania that IBCT was more potent in dealing with marital dissatisfaction than CBT. He further indicated that although IBCT generally was more efficacious, females were more responsive to CBT than IBCT.

Suarez (2014) also found in Mississippi, USA that marital quality was significantly improved using IBCT than CBT on disenchanted marriages. He found that the two treatment groups had improved significantly than those in the control. He explained that, integrated therapy has the advantages of looking at all the problem areas of the client as compared to dwelling on the mental framework of the clients which the CBT possess. The assertion of Suarez may be deficient at a point in the sense that all challenges span from our mental processes. Myers (1998) believes that marital distress is a function of the mind which sees married people going through psychopathological tendencies which manifest in the behaviour of the spouses. To effectively deal with this psychopathology in marriage, the therapist needs to reorient the dissatisfied spouse and that implies working on the mind-set of the individual. This is an indication that the behaviour people put up is an indication of their thought processes. This is why during therapy, the counsellor needs to assist couples to change their mental incongruities and replace them with positive thoughts that will be translated into acceptable behaviours.

Again, the study revealed that IBCT was more effective than CBT in helping couples with marital distress. Mensah (2013) had contrary finding to this. He found among dissatisfied couples that CBT was more effective in improving their satisfaction levels than IBCT. He added that the difference between the two

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groups was statistically significant. This might be due to the fact that such clients may change their minds and respond to issues in the positive way and so long as a person changes his/her illogical thoughts to logical ones, change is imminent.

The current finding is still in harmony with the finding of Aluoch (2010) who found in Mombasa, Kenya that IBCT was more efficacious than CBT in improving the marital success of married people. She revealed further that although IBCT was efficacious than CBT the difference between was not significant in improving marital success.

The findings of this study, however, contradicts the findings of Olara-Okello (2014) who found in Entebe, Uganda that CBT was more efficacious than IBCT in managing marital distress. He revealed that though both therapies were found to be efficacious in managing marital distress, CBT was more efficacious. He added that marriages near divorce needed IBCT more than CBT as he found that couples whose marriages are near divorce needed acceptance and change. However, his study had a few of such respondents and that could probably account for CBT being more efficacious than IBCT. In addition, the characteristics of the respondents in Uganda might not be the same as the characteristics of those in Ghana and this might have accounted for why CBT was more efficacious than IBCT.

Individual Dimensions of Marital Distress (Hypothesis 3)

This hypothesis sought to find out the performance of the various dimensions of marital distress; the components that constituted the instrument that measured marital distress were also assessed. There were seven sub scales and the results

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revealed that six areas had improved significantly except financial management. It was believed that financial status of the participants remained unchanged and as such practicing financial prudence in vacuum was always going to be a problem. Françoise (2012) revealed that talking about financial prudence is one thing and practicing financial management when you have the money with you is another. This implies that people need to put strategies in place in order to improve upon their finances practically.

The finding buttresses Augustines (2015) who found no improvement in financial management of participants after they have been taken through rational emotive behavioural therapy. Augustine's study was carried out in Zimbabwe on dissatisfied couples who sought intervention to improve their marriages.

The study is also in support of the study of Eshun (2011) who found significant improvement in the marital conflict and personal communication of couples after they were taken through treatment in solution brief focus therapy. Eshun maintains that marital conflicts and especially personal communication issues were the major issues that were found to have torn the marriage apart. He explained that what might have worked was the fact that communication is seen as the engine of the marriage vehicle (Saani, 2013). Once it works well the vehicle moves well. Communication has the ability to transcend all other area of marriage. Effective communication therefore prevents marital conflicts, marital violence and promotes intimacy. Effective personal communication also leads to joint communication with spouses. It was, therefore, not surprising that joint

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communication also saw signification improvement after intervention in the current study.

Stress is the wear and tear of the body and mind of an individual as a result of demands or pressures of everyday events. According to D'Arcy (2007), stress is the body's way of rising to a challenge and preparing to meet tough situation with focus, strength, stamina and heightened alertness. This presupposes that there is stress in all facets of our lives of which marriage is part. These stressful life events are at times responsible for frustrations with other factors in putting married individuals into marital distress. This was the case of the current study; stressful life events were one of the factors that were responsible for marital distress among couples. However, after intervention, couple's marital quality had improved significantly. This finding is consistent with the finding of Pearles (2014) who found that cognitive behavioural therapy was effective in dealing with marital distress as participants had improved on stressors of life.

According to Dabone (2012), intimacy and affection are the pinnacle of successful marriage and hence a lack of it or a low level of it cumulates in marital dissatisfaction. In the current study, lack of intimacy was of one the factors that were considered to be responsible for marital distress. The results, however, revealed that the participants had significantly improved in terms of intimacy after they were taken through IBCT and CBT. This is an indication that respondents were having challenges regarding intimacy and affection and this improved after the intervention.

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Marital Distress with regard to Gender (Hypothesis 4)

This hypothesis was tested to find out whether there was any significant difference in marital distress with regard to gender. The findings of the study showed that the level of marital distress among the participants did not differ based on gender. This means that both male and female participants who were exposed to the two therapies (CBT and IBCT) did not significantly show any unique difference regarding marital distress. In view of this finding, the null hypothesis (H_0) of Hypothesis 4 which states that there is no significant difference in marital distress with regard to gender was retained.

The findings of the present study was consistent with Gager and Sanchez (2003) who found no significant differences in the mean levels of husbands' and wives' marital satisfaction. Gager and Sanchez using national probability data from the National Study of Families and Households, found no gender differences between wives and husbands concerning marital distress. This means that both men and women are disturbed when things do not go the way they expected. In addition, stress related issues are not limited to gender differences.

The finding of the study was, however, at variance with the study of Obodia (2012) who found statistical significant difference between male and female married people in terms of marital distress. He added that the females were more distressed in their marriage than males in a study he conducted in the Ajumako District of the Central region. Again, the current study was also inconsistent with the findings of Kennedy, Einstein and Downar (2013) as well as Kessler (2003) who found that women are more prone than men to experience depressive episodes

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in marriages. They emphasised that this distinction might be based on biological and hormonal differences women experience. The findings of the present study is also incongruent with Almeida and Kessler (1998) who found that emotional distress which comes from a marital argument is more pronounced for wives than husbands suggesting that wives might be more reactive than husbands to arguments in marriage. This might depend on the personality type of the women used for his study because choleric dominated women never give up easily on issues as they will fight on when others give up.

Marital Distress with regard to Age (Hypothesis 5)

This hypothesis tested whether there was any significant difference in marital distress with regard to age. The findings of the study revealed that the level of marital distress among the participants did not differ in terms of age. This implies that regardless of the various ages of the participants who were exposed to the two therapies (CBT and IBCT), no significant difference was observed. In view of this finding, the null hypothesis (H_0) of Hypothesis 5 which states that there will be no significant difference in marital difference with regard to age was retained.

This finding was in agreement with that of Peters (2014) in Lusaka, Zambia, that marital satisfaction of disenchanted couples revealed no significant difference in age of couples. Peters explained that premarital counselling, in his view, might have compensated the younger couples and built up with experience as the older generation has. Dabone (2012) similarly found no significant difference between young and old married people in terms of marital satisfaction. Even though his findings revealed that older married people were more satisfied in their marriages

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than younger married people, the difference was not significant. The current researcher hopes that there are a lot of things that make married couple happy and satisfied in their relationship. This might not necessarily be due to age. Age of a spouse may be irrelevant when the factors for successful marriage are missing.

Furthermore, the findings of the current study are, however, not in agreement with those of Lee (1977) who found that while the age at marriage increased, marital satisfaction increased leading to a decrease in marital distress. Lee (1977) studied the relationship between marital satisfaction, age at marriage, and marital role performance.

The finding was least expected by the researcher because he felt that with all the experiences gathered by older married people should bring about significant differences between them and younger folks. The researcher envisaged that the older generation has several responsibilities to fulfil in the marriages and the society that obviously distress them. In like manner, young married people strive to make impact in society, anxiously wait for childbirth and others which also put them in distress positions. This probably could account for the finding of the current study.

Marital Distress with regard to Length of years in Marriage (Hypothesis 6)

This hypothesis tested whether there was any significant difference in marital distress with regard to length of years in marriage. The findings of the study revealed that the level of marital distress among the participants did not differ in terms of length of years in marriage. This implies that regardless of the number of years participants had spent in marriage, no significance difference was observed upon exposing the participants to the two therapies (CBT and IBCT). In view of

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this finding, the null hypothesis (H_0) of Hypothesis 6 which states that there will be no significant difference in marital distress in terms of length of years in marriage was retained.

The findings of this study agreed with Nyameye (2015) who found no significant difference in the marital quality of spouses in terms of the length of years in marriage. His study revealed that those married for a longer period of time were more distressed than those married for a shorter period of time. In a similar study by Atitola (2013) the length of time in marriage was the least predictor for marital success. Out of the 15 predictors of marital success, the length of time in marriage placed 15th. He was of the opinion that, finances, temperament, in-law influences were the most contributing factors to marital distress. This implies that the availability of money, good temperament of spouse and less in-law interference are very good factors that could lead to marital satisfaction and not the length of the relationship.

The findings of the present study is however inconsistent with the findings of Kamp-Dush, Taylor, and Kroeger (2008) who found that both spouses experienced a decline in marital happiness over time. They concluded that, over time, people become increasingly less satisfied with their relationships, though this lack of satisfaction is mediated by the spouses' original happiness in their marriages. This might be possible when the factors needed for a happy and satisfying marriage are absent.

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Summary of Results

1. The interventions based on the CBT and IBCT therapies were found to be effective in reducing marital distress among Christian Couples in the Cape Coast Metropolis.
2. The IBCT was found to be more effective in the treatment of marital distress.
3. The therapies were effective for the various dimensions of marital distress. However it was not effective in dealing with financial management challenges and difficulties.
4. The level of marital distress of the respondents in the Cape Coast metropolis did not differ based on age.
5. The level of marital distress of the respondents in the Cape Coast metropolis did not differ based on gender.
6. The level of marital distress of the respondents in the Cape Coast metropolis did not differ based on length of marriage.

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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

The purpose of this study was to ascertain whether using Integrated Behavioural Couples Therapy and Cognitive Behavioural Therapy as intervention strategies could reduce marital distress among Pentecost Christian couples in Ghana. This chapter presented a summary of the study, key findings, the conclusions drawn as well as the recommendations made. The contribution of the study to knowledge, implications for counselling and suggestions for further study has also been presented.

Overview of the study

People marry for various reasons such as for companionship, support, prestige, sexual satisfaction and procreation. Marriage is expected to give the couple joy, comfort, peace and also assist them to attain certain objectives in the relationship. However, research has shown that many couples are suffering from distress in their relationships. Such people are frustrated, dissatisfied, disappointed and often regret being married. The purpose of this study therefore was to ascertain whether using Integrated Behavioural Couples Therapy and Cognitive Behavioural Therapy as intervention strategies could reduce marital distress among Christian couples in Ghana. Specifically, the study sought to attain the following objectives.

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1. To find out the effects of Integrated Behavioural Couples Therapy and Cognitive Behavioural Therapy on marital distress.
2. Find out which of the two treatment strategies (IBCT, CBT) would be more effective in reducing marital distress
3. To find out the effectiveness of the various dimensions of the instrument on marital distress
4. To find out the influence of gender on the marital distress of participants in IBCT and CBT.
5. To determine the influence of age on marital distress of participants in IBCT and CBT.
6. To ascertain the influence of length of marriage on marital distress of participants in IBCT and CBT.

To ascertain these purposes of the study, the following hypotheses were tested to examine the relationship between the independent and the dependent variables.

Hypotheses

The following hypotheses guided the conduct of the study.

H_0 1: There is no significant difference in the effectiveness of the interventions (CBT and IBCT) on marital distress among couples in the Cape Coast Metropolis.

H_1 1: There is a significant difference in the effectiveness of the interventions (CBT and IBCT) on marital distress among couples in the Cape Coast Metropolis.

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$H_0 2$: There is no significant difference in the effectiveness of IBCT in reducing marital distress among married couples as compared to CBT.

$H_1 2$: There is a significant difference in the effectiveness of IBCT in reducing marital distress among married couples as compared to CBT.

$H_0 3$: There is no significant difference in the effectiveness of the interventions on the various dimensions of marital distress.

$H_1 3$: There is a significant difference in the effectiveness of the interventions on the various dimensions of marital distress.

H_0 4: There is no significant difference in marital distress with regard to gender.

H_1 4: There is a significant difference in marital distress with regard to gender.

H_0 5: There is no significant difference in marital distress with regard to age of the participants.

H_1 5: There is a significant difference in marital distress with regard to age of the participants.

H_0 6: There is no significant difference in marital distress with regard to length of marriage

H_1 6: There is a significant difference in marital distress with regard to length of marriage

The study made use of the pre-test, post-test control group design, a type of the quasi-experimental research design. Experimental research describes the process that a researcher undergoes to control certain variables and manipulate others and observe if the results of the experiment reflect the manipulations that

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cause a particular outcome. Christian couples going through distress in their relationships in the Cape Coast Metropolis were selected for this study.

The study made use of an initial sample of 200 participants constituting Christian married couples. Out of this, the researcher sampled 60 participants who were severely distressed using a compendium of instrument on Conceptualising and Measuring "Healthy Marriages" for Empirical Research and Evaluation Studies (Task One Part II), developed by Carrano, Cleveland, Bronte-Tinkew and Moore (2003). The researcher then selected 60 respondents who were severely distressed for the study. This number was divided into three groups of 20 participants each using the systematic sampling procedure. The first group was for IBCT, the second group for CBT and the third group was the control group. Data collected was analysed using descriptive and inferential statistics. Hypotheses 1 and 2 were tested with the two-way mixed ANOVA to find out the effectiveness of the interventions in reducing marital distress over time. Hypothesis 3 was tested with one-way MANOVA to find out the effectiveness of the interventions on the seven dimensions or measures of marital distress. The seven dimensions of the marital distress were partitioned to test whether the interventions had been effective regarding the various dimensions. Hypotheses 4, 5 and 6 were tested with the three-way multivariate analysis of variance. This test was done on the pre-intervention levels of marital distress of the respondents because the hypotheses tested whether there were gender, age category and length of marriage category differences among the respondents.

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Key findings of the Study

The key findings are presented in line with the hypotheses of the study as follows.

The first hypothesis tested whether CBT and IBCT therapies have been effective in reducing the level of marital distress among the participants. The relative effectiveness of the two therapies were also assessed. The effectiveness of interventions based on the CBT and IBCT therapies were found to be effective in reducing marital distress among Christian couples in the Cape Coast Metropolis. Also, it was found out that the marital distress level of the participants reduced after the intervention using CBT and IBCT. This implies that the two therapies were efficacious in reducing marital distress.

The second hypothesis tested if there is a statistically significant difference in the effectiveness of IBCT in reducing marital distress among married couples as compared to CBT. The pre-intervention scores for CBT, IBCT and the control group were basically around the same figure, but there were variations among the post intervention scores. This is a clear indication that IBCT was found to be more effective in the treatment of marital distress than CBT.

The third hypothesis tested the effectiveness of the various dimensions of marital distress. The post-test scores were significantly lower than the pre-test scores across all the dimensions, except financial management challenges. The therapies were therefore very effective for the various dimensions of marital distress. However it was not effective in dealing with financial management challenges and difficulties.

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The fourth hypothesis also tested if age has any effect on the level of marital distress. The results of the study revealed that the level of marital distress of the respondents in the Cape Coast metropolis did not differ on the basis of age.

The fifth hypothesis tested if the level of marital distress of the respondents in the Cape Coast metropolis differs on the basis of gender. The multivariate test results showed that the level of marital distress among the respondents did not differ based on gender. This implies that gender has no effect on the level of marital distress among couples in Cape Coast Metropolis.

The sixth hypothesis tested if the level of marital distress of the respondents in the Cape Coast metropolis differs on the basis length of years in marriage. The level of marital distress of the respondents in the Cape Coast metropolis did not differ based on the length of years in marriage.

Conclusions

The following conclusions were drawn from the findings of the study:

From the study, IBCT and CBT were both effective interventions in reducing marital distress. Meanwhile, IBCT was found to be more efficacious in reducing marital distress or is a better intervention strategy than CBT. Regarding the dimensions of marital distress investigated, the therapies were effective in all, except financial difficulty. Marriage counsellors need to be careful when selecting therapeutic strategies that could be used in assisting couples or clients going through distress in their marriages. One thing counsellors may need to consider is how efficacious the various therapies are in reducing marital distress. The use of

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IBCT was seen as more efficacious perhaps due to its problem solving nature, tolerance, acceptance and change.

The study revealed that the therapies (IBCT and CBT) worked for the various dimensions of marital distress with the exception of financial difficulties and management. This is an indication of the unique nature of money. The interventions, though, very effective in changing a lot of things in the lives of the couples, could not put money directly into their pockets. This implies that their financial status was the same. Finally, age, gender and length of years in marriage did not have any significant effect on the distress level of the participants. This implies that marital distress has no regard for age, gender and the length of years in marriage.

Final Observed Model

Figure 7 presents the final observed model after the intervention.

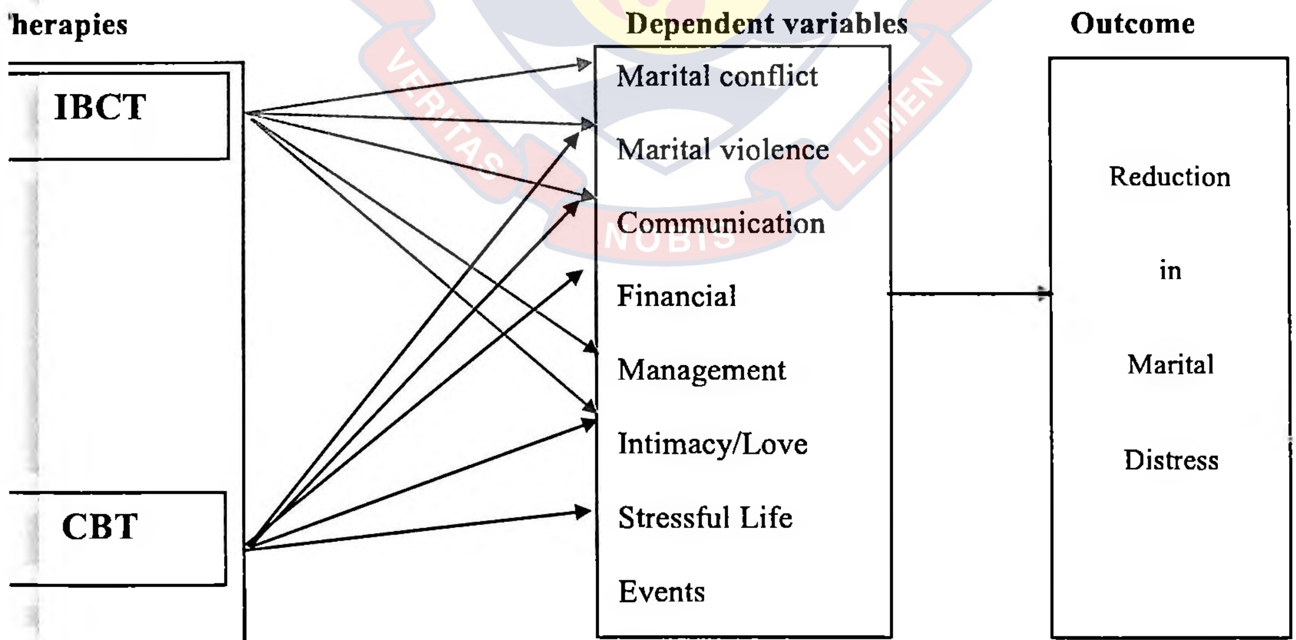

Figure 7- Final observed model

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The conceptual framework of this work proposed that Integrative Behavioural Couple Therapy (IBCT) and Cognitive Behavioural Therapy (CBT) could be used as intervention strategy in reducing marital distress among Pentecostal couples in the Central Region of Ghana. The study also anticipated that age, gender and length of years of marriage could influence the reduction of marital distress among the participants. The final observed model showed that Integrative Behavioural Couple Therapy (IBCT) and Cognitive Behavioural Therapy (CBT) were effective in reducing five dimensions of marital distress among the participants in exception of financial management difficulties. Also, age, gender and length of years of marriage did not have any influence in reducing marital distress among the participants. The final observed model is illustrated in Figure 7. This implies that counsellors can use the two therapies (IBCT and CBT) to assist couples going through marital distress.

Recommendations

Findings from this study have the under listed recommendations for policy and programme interventions in the institution of marriage as a whole.

Firstly, the study recommended that marriage counsellors should resort to the use of IBCT and CBT in assisting married couples out of marital distress and other challenges confronting married couples. The Ghana Psychological Association, The Ghana Psychological Council and the Counsellors Association of Ghana need to encourage her members to resort to the use of therapies, theories and techniques for counselling clients. Churches and other religious organisations must

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resort to the use of qualified and well trained counsellors who will use theories and therapies for pre and post marital counselling.

Secondly, the study recommended that counsellors should use Integrated Behavioural Couples Therapy to assist clients going through marital distress as a result of its unique qualities. Heads of churches and ministers of religion should ensure that marriage counsellors in their churches are well trained and educated to provide the requisite assistance to clients and not only resort to preaching and prayers. Counsellors should continue to test the efficacy of various theories and use the better ones to assist clients.

Thirdly, the study recommended that church leaders and ministers should not only be concerned about the spiritual development of couples. Church leaders need to consider the financial development of couples as well. They also need to draw out programmes that will see to the career development of married couples. Church leaders also need to create fund to support the financially disadvantaged and also develop the entrepreneurial skills of couples. This will make couples financially sound to take care of their families and also support the church.

Fourthly, the study recommended that people of all age groups should consider using various strategies to manage distress in their relationships. Since the results of the study indicated that distress is not limited to any age level, church leaders must shoulder the responsibility of educating their members on stress management strategies.

Fifthly, the study recommended that husbands and wives in churches should understand that issues of stress are not limited to gender. Men and women

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are all affected. Church leaders should therefore educate the men and women in their churches, not to see themselves as powerful, but to understand that they could be affected by stress and therefore take issues of stress management very seriously.

Finally, since marital distress is not limited to the length of years in marriage, the church leadership should build up strong premarital counselling as well as post marital counselling. This will ensure that even those who are already married are given enough doses of marital counselling as a way of promoting stress- free and stable marriages. The Ghana Pentecostal Council and the Christian Council of Ghana should be responsible for this.

Implications for Counselling

In the first place, getting 60 severely distressed participants for the study is an indication that Christians are going through stress in the church despite their faith in God. This calls for increasing counselling services in churches, not only on marital issues but also on other areas of human endeavour. The finding that CBT and IBCT are both efficacious in reducing marital distress implies that it is time to test the various theories and see how practicable and how useful they are in assisting people out of the various challenges confronting them. This also implies that counsellors in churches need to be well trained and educated since untrained counsellors cannot use theories and techniques in counselling clients. Heads of churches and religious leaders should be made responsible for this.

Secondly, the finding that IBCT is more efficacious than CBT implies that until theories are tested, one may not know the one that is better or applicable in the Ghanaian or African setting since most of these theories were propounded in

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western countries. This implies that counsellors need to resort to using IBCT in assisting couples going through marital distress than using CBT. This further implies that church leaders must attach more importance to counselling to make it more effective in assisting people in churches out of problems.

Thirdly, the finding that financial difficulties that produces stress changed insignificantly after the post-test implies that married couples may continue to go through stress when their financial status remained the same. This implies that counsellors need the counsel married couples on financial autonomy and ways of having additional income to supplement their income.

Fourthly, the finding that age did not change significantly with regard to marital distress implies that stress has no regard for age. Both the young and the old will have their share when it comes to stress. This further implies that counsellors need to offer counselling and education to people of all ages in the church on stress management as a way of assisting them to manage stress in all spheres of life, irrespective of their ages.

Fifthly, the findings that gender did not change significantly with regard to distress implies that issues of stress is not limited to male or female, neither can we conclude that men are stronger in terms of stress than women or vice versa. This implies that counsellors need to give equal attention to both sexes during counselling.

Finally, the finding that length of marriage did not change significantly with regard to distress implies that issues of stress might start from the beginning of the marriage to the end of the marriage. This also indicates that both young and

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old married couples could still go through marital distress. This implies that counsellors in churches need to be at the top of their jobs for all married couples with no regard to the length of marriage. This is a further indication that guidance services are truly a cradle to grave activity and should be treated as such.

Contribution to knowledge

It must be pointed out that within the context of doctoral research, an original contribution to knowledge is a very shaded term since it does not mean an enormous breakthrough but rather to demonstrate that one has a good grasp of how research is normally done in a proposed area of study being specialized in.

According to Silverman (2007), the ability of any research is to contribute to knowledge that could be displayed in four key areas. These are developing a concept, thinking through the methodology, building on an existing study and being able to change directions. In this regard, this study can be seen as generally building on existing studies to add to knowledge in the institution of marriage. Among the modest contributions made by this study in this area are:

Firstly, most studies carried out in the country explored the level of marital satisfaction among couples in Ghana by using existing scales on marital satisfaction. This study on the contrary examined one of the major causes of marital dissatisfaction which is marital distress. Literature revealed that marital dissatisfaction occurs when couples go through distress in their relationships. Reducing marital distress will greatly promote the marital satisfaction and stability that married couples greatly desire.

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Secondly, most studies conducted on marriage in the country made use of the descriptive survey design which is limited to testing theories to see their efficacy in handling human challenges. This study however, made use of the quasi-experimental design in order to test the efficacy of counselling theories and their effectiveness and applicability in the Ghanaian setting. Counsellors are therefore encouraged to test theories and ensure their relevance in meeting specific needs of clients.

Thirdly, the revelation that married couples in churches go through stress in their relationships is a great stride to update church leaders to expand their horizons of counselling as prayers alone may not remove stress and its effects on marital relationships.

Fourthly, the revelation that financial difficulties affect the stress level of married couples is an indication that couples' attitude towards financial issues could increase their distress level. This calls for church leaders to promote the financial stability of their members and limit the monetary demands made on church members but also support church members financially.

Finally, there is a revelation that stress affects all kinds of married couples not withstanding age, gender and length of years in marriage. The call for stress management at all levels of marriage should be seen as indispensable in the journey of marriage.

Suggestions for Further Research

Looking at the present scope of the study, it is suggested that the same research work be carried out in other regions of Ghana using the same design,

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instrument and the intervention theories. This might lead to the development of concepts in terms of the right theories to use in reducing marital distress in Ghana. The researcher also suggests that the same work could be done using other therapies to see how efficacious they might be in managing marital distress.

Finally, further researches could be carried out using more participants than the current study. Other designs, instruments and statistical tools could be employed in conducting similar studies as a way of comparing their outcomes.

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APPENDIX A

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

FACULTY OF EDUCATIONAL FOUNDATIONS

DEPARTMENT OF GUIDANCE AND COUNSELLING

Questionnaire

This study is conducted in partial fulfilment of an award of a doctorate degree in guidance and counselling. The purpose of this study is to examine **the efficacies of Integrative Behavioural Couples' Therapy and Cognitive Behavioural Therapy in reducing marital distress in Ghana.** Any information you provide is purely for academic purposes, and will not be disclosed nor held against you. Participation in this study is voluntary.

Thank You, Stephen Doh Fia
(Researcher).

Provide response to each of the following items.

SECTION A- Demographic Characteristics

Please tick (√) your response.

1. Gender

   Male [ ]

   Female [ ]

2. Age range

   20-30years [ ]

   31 – 40years [ ]

   41 – 50years [ ]

   51- 60years [ ]

3. Organization/Institution

   ....

4. Length of marriage

   1-5 years [ ]

   6-10years [ ]

   11-15years [ ]

   16-20years [ ]

   21-25years [ ]

   25-30years [ ]

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SECTION B – Causes of marital distress

Domain: Marital Conflict

The following are the causes of marital distress. Please indicate (√) how each of the following statements applies in your situation.

1 = Never
2 = Rarely
3 = occasionally
4 = Frequently
5 = Very frequently

Statement	1	2	3	4	5
1. My partner acted like I was his personal servant.					
2.My partner went out of the house or yard during a disagreement					
3. My partner monitored my time and made me account for my whereabouts.					
4. My partner yelled or shamed me in front of others.					
5. My partner threatened to take the children away from me.					
6.My partner paid attention to his/her appearance only					
7.My partner helped with housework when asked					
8.My partner engaged in extra-marital sexual relations					
9. My partner blamed me when he was upset.					
10. My partner did not do a fair share of the household tasks.					
11. My partner was stingy in giving me money to run our home.					
12.My partner was insensitive to my sexual needs and desires					
13.My partner accused me of having an affair with another man/woman					
14. Little arguments escalate into ugly fights with accusations, criticisms, name-calling, or bringing up past hurts.					
15. My partner seems to view my words or actions more negatively than I mean them to be.					

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16. When we have a problem to solve, it is like we are on opposite teams.					
17. My partner criticizes or belittles my opinions, feelings, or desires.					
18. My partner did not do a fair share of child care.					
19. My partner used our money or made important financial decisions without talking to me about it.					
20.My partner prepares meals on time					

Domain: Marital Violence

Please indicate (√) how each of the following statements applies in your situation.

1 = Very rarely
2 = Rarely
3 = Some of the time
4 = Most of the time
5 = All of the time

Statement	1	2	3	4	5
1. My partner physically forces me to have sex.					
2.My partner beats me when he/ she is drank					
3. My partner threatens me with a weapon.					
4. My partner badly hurts me while we are having sex.					
5. My partner makes me afraid for my life.					
6.My partner beats me so hard that I must seek medical help					
7.My partner pushes me around violently					
8.My partner slaps me					
9.My partner at times hits me with a metal rod					
10.My partner spanks me					
11. My partner bites or scratches me so badly that I bleed or have bruises.					
12. My partner acts like he or she would like to kill me.					

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13.My partner beats me in the face so badly that I am ashamed to be seen in public					
14. My partner tries to suffocate me with pillows and towels					
15. My partner knocks me down and then kick or stamp over me					
16.My skin is violently pinched or twisted by my partner					
17.My partner boots me like football					
18. My partner knocks my head					
19.My partner throws stones at me					
20.My partner poured hot water on me					

Domain:(a)Personal Communication

Please indicate (√) how each of the following statements applies in your situation.

1 = Strongly agree
2 = Moderately agree
3 = Undecided
4 = Moderately disagree
5 = Strongly disagree

Statement	1	2	3	4	5
1. It is not very easy for me to express all my true feelings to my partner.					
2.Sometimes I have trouble believing everything my partner says to me					
3.My partner sometimes makes comments which put me down					
4. I do not always share negative feelings I have about my partner because I am afraid he/she will get angry.					
5. I am very satisfied with how my partner and I talk with each other.					
6. I am sometimes afraid to ask my partner for what I want.					
7. My partner is always a good listener.					

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8. I often do not tell my partner what I am feeling because he/she should alreadyknow.					
9.I find it hard to tell my husband /wife certain things because I am not sure how he /she will react					
10. My spouse and I cannot talk about our communication problems.					
11. When we are having a problem, my partner often gives me the silent treatment.					
12. I am hesitant to develop a "deep" conversation with my spouse.					
13. During periods of conflict I always let my spouse do the talking.					

Domain :(b)Joint Communication

Please indicate (√) how each of the following statements applies in your situation.

1= Never
2= Once in a while
3= Sometimes
4= Frequently
5= Always

Statement	1	2	3	4	5
14. How often do you and your partnerdiscuss the way you would like yourmarriage to be five years from now?					
15. How often do you and your partner make deliberate, intentional changes in order to strengthen your relationship?					
16. How often do you and your partner make specific changes in your priorities in order toenhance your marriage?					
17. To what extent do you think you and your partner agree on long-term goals for your marriage?					
18. How often does your partner make a deliberate effort to learn more about you so he can be more pleasing to you?					
19. How often does your partner consider specific ways in which he can change in order to improve your relationship?					

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20. How often do you and your partner discuss the primary objectives you have for your Relationship/marriage?					

Domain: Marriage and Financial Management/Difficulties

Please indicate (√) how each of the following statements applies in your situation.

1 = Strongly agree
2 = Moderately agree
3 = Undecided
4 = Moderately disagree
5 = Strongly disagree

Statement	1	2	3	4	5
1. Sometimes I wish my partner was more careful in spending money.					
2. We always agree on how to spend our money.					
3. It bothers me that I cannot spend money without my partner's approval.					
4. We have difficulty deciding on how to handle our finances.					
5. We are both aware of our major debts, and they are not a problem for us					
6. We keep records of our spending so we can budget our money.					
7. We are both aware of our major debts, and they are problem for us.					
8. Deciding what is most important to spend our money on is a concern for us.					
9. I am satisfied with our decisions about how much we should save.					
10. We have difficulty deciding on how to handle our finances.					
11.We often run out of money for daily needs					
12.We resort to impulse buying and this has depleted our savings					
13.We often sold our property in order to make ends meet					

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14.We often borrow money to take care of our home every month					
15.We can't stay at home because our debtors are always chasing us for their money					
16. A greater portion of our income is always used to service debts					
17.We were often taken to court for the non-payment of bank loans					
18.My partner lost his/her job and my income cannot sustain the family					
19. Our children were sacked from school for non-payment of school fees					
20.Our financial resources cannot meet our health needs					

Domain: Intimacy/Love

Please indicate your perception of your relationship using the following scale.

1 = Never
2 = Occasionally
3 = Sometimes
4 = Frequently
5 = Always

Statement	1	2	3	4	5
1. When my partner gets angry with me, I still love him/her fully and unconditionally.					
2.I share deeply personal information about myself with my partner					
3. We can accept each other's criticism of our faults and mistakes.					
4. I cannot relax if I suspect that my partner is with someone else.					
5.I am willing to share myself and my possessions with my partner					
6.I have a comfortable relationship with my spouse					
7.I receive considerable emotional support from my spouse					
8.There is nothing more important to me than my relationship with my partner					
9. I cannot imagine another person making me as happy as my spouse does.					

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10. I am able to count on my spouse in times of need.					
11. My partner and I have the right physical "chemistry" between us.					
12. I feel that my partner and I were meant for each other.					
13. I cannot be happy unless I place my partner's happiness before mine					
14. I would endure all things for the sake of my partner.					
15. I'd get jealous if I thought my partner was falling in love with someone else.					
16. My body trembles with excitement at the sight of my partner					
17. I get extremely depressed when things don't go right in our relationship.					
18. No one could love my partner like I do.					
19. I would rather be with my partner than anyone else.					
20.If I were separated from my partner for a long time, I would feel intensely lonely					

Domain: Marriage and stressful life events

Please indicate your perception of your relationship using the following scale.

1 = Strongly agree
2 = Moderately agree
3 = Undecided
4 = Moderately disagree
5 = Strongly disagree

Statement	1	2	3	4	5
1.There is increased conflict with in-laws or relative					
2. There is increase in the number of tasks or chores left undone					
3. I experience difficult moments in my marriage					
4. I took a loan to redeem expenses					
5.Change in conditions (economic, political, weather) hurts the family business					

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6.Increased strain on family "money" for medical/dental expenses					
7. Increased strain on family "money" for food, clothing, energy, home care etc					
8. Increased strain on family "money" for child(ren)'s education					
9. I became unemployed or you were seeking work unsuccessfully for more than one year					
10. Something you valued was lost or stolen.					
11.Child became seriously ill or injured					
12. Close relative or friend of the family became seriously ill					
13. Increased difficulty in managing a chronically ill or disabled member					
14. Increased responsibility to provide direct care or financial help to husband's and/or wife's parent(s)					
15. Death of husband or wife's parent or close relative					
16. Married son or daughter was separated or divorced					
17. A serious illness, injury, or assault happened to a close relative.					
18. You had a serious problem with a close friend, neighbor, or relative.					
19. A member dropped out of school or was suspended from school					
20. Frequent lorry accident with damages					

Scoring scale

Total Score	Distress Severity Level
20-40	Low
41-60	Moderate
61-80	Severe
81-100	Very severe

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APPENDIX B

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

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E-MAIL: irb@ucc.edu.gh
OUR REF: UCC/IRB/A/2016/169
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

C/O Directorate of Research, Innovation and Consultancy

5TH SEPTMBER, 2017

Mr. Stephen Doh-Fia
Department of Guidance and Counselling
University of Cape Coast

Dear Mr. Doh-Fia,

ETHICAL CLEARANCE –ID :(UCCIRB/CES/2017/26)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol titled **'Efficacies of Integrative Behavioural Couples Therapy (IBCT)N and Cognitive Behavioural Therapy (CBT) in Reducing Marital Distress in Ghana.'**

This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu
Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST
Date:..................................

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APPENDIX C

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF EDUCATIONAL FOUNDATIONS
DEPARTMENT OF GUIDANCE AND COUNSELLING

Telephone: 0332091854
Email: dgc@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref:
Your Ref:

6th February, 2017

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION

We introduce to you, Stephen Doh Fia who has completed his course work in Ph.D (Guidance and Counselling) programme at the Department of Guidance and Counselling at the University of Cape Coast. He has selected your organisation/institution/church from which to gather data that will facilitate the writing of his thesis entitled ***"Efficacies of Integrative behavioural Couples Therapy and Cognitive Behavioural Therapy in reducing Marital Distress in Ghana"***. We are by this letter affirming that, the information he will obtain from your organisation will be solely used for academic purposes.

We would be most grateful if you could provide him with the necessary assistance.

Thank you.

Yours faithfully,

Dr. Bakari Yusuf Dramanu
HEAD OF DEPARTMENT

VERITAS NOBIS LUMEN

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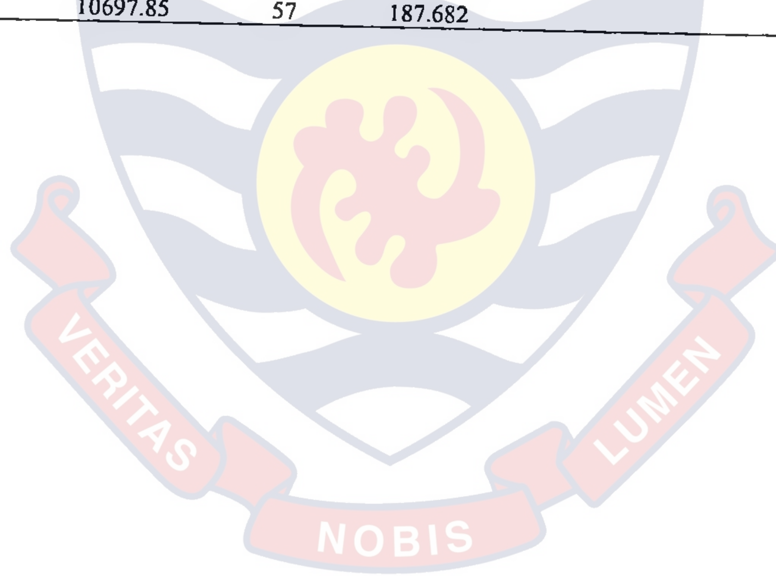
APPENDIX D-1

Two Way Mixed ANOVA Results

Source		Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared	Observed Power[a]
Test	Sphericity Assumed	554880.0	1	554880.00	2956.497	.000	.981	1.000
	Greenhouse-Geisser	554880.0	1.0	554880.00	2956.497	.000	.981	1.000
	Huynh-Feldt	554880.0	1.0	554880.00	2956.497	.000	.981	1.000
	Lower-bound	554880.00	1.0	554880.00	2956.497	.000	.981	1.000
Test * Group	Sphericity Assumed	286676.15	2	143338.08	763.730	.000	.964	1.000
	Greenhouse-Geisser	286676.15	2.0	143338.08	763.730	.000	.964	1.000
	Huynh-Feldt	286676.15	2.0	143338.08	763.730	.000	.964	1.000
	Lower-bound	286676.15	2.0	143338.08	763.730	.000	.964	1.000
Error(Test)	Sphericity Assumed	10697.85	57	187.68				
	Greenhouse-Geisser	10697.85	57	187.682				
	Huynh-Feldt	10697.85	57	187.682				
	Lower-bound	10697.85	57	187.682				



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APPENDIX D-2

Means and Standard Deviations of the Dimensions of Marital Distress

	Group	Pretest post test	Mean	Std. Dev	N
Marital conflict	CBT	Pre-test	59.05	9.15	20
		Post-test	43.75	3.26	20
	IBCT	Pre-test	62.25	8.24	20
		Post-test	34.70	2.79	20
	CTRL	Pre-test	57.65	5.92	20
		Post-test	54.40	5.59	20
Marital violence	CBT	Pre-test	60.15	4.17	20
		Post-test	41.50	4.08	20
	IBCT	Pre-test	60.70	2.59	20
		Post-test	24.40	2.56	20
	CTRL	Pre-test	60.60	2.78	20
		Post-test	59.25	3.37	20
Personal communication	CBT	Pre-test	56.70	4.40	20
		Post-test	45.20	4.55	20
	IBCT	Pre-test	56.10	4.73	20
		Post-test	27.75	5.37	20
	CTRL	Pre-test	57.90	4.13	20
		Post-test	56.50	3.95	20
Joint communication	CBT	Pre-test	57.30	3.49	20
		Post-test	46.90	4.09	20
	IBCT	Pre-test	59.40	4.53	20
		Post-test	25.90	3.71	20
	CTRL	Pre-test	58.65	3.80	20
		Post-test	55.60	3.83	20
Financial management	CBT	Pre-test	83.00	8.55	20
		Post-test	76.15	6.93	20
	IBCT	Pre-test	81.55	7.67	20
		Post-test	70.45	9.53	20
	CTRL	Pre-test	80.40	8.46	20
		Post-test	75.90	13.71	20
Intimacy	CBT	Pre-test	84.50	9.77	20
		Post-test	49.30	3.21	20
	IBCT	Pre-test	85.80	8.79	20
		Post-test	27.15	4.12	20

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	CTRL	Pre-test	85.70	8.53	20
		Post-test	83.30	14.89	20
	CBT	Pre-test	89.80	11.03	20
		Post-test	47.75	5.31	20
Stressful events	IBCT	Pre-test	86.50	11.78	20
		Post-test	28.25	2.86	20
	CTRL	Pre-test	92.25	5.63	20
		Post-test	90.85	4.40	20

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APPENDIX D-3

Test of between effects for differences among experimental conditions

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Sqr
Intercept	Dif_Cnflict	14168.067	1	14168.07	202.76	.000	.781
	Dif_Violence	21131.267	1	21131.27	989.47	.000	.946
	Dif_PersonalCom	11343.750	1	11343.75	389.43	.000	.872
	Dif_JoinCom	14695.350	1	14695.35	447.28	.000	.887
	Dif_FinMgt	3360.017	1	3360.01	31.75	.000	.358
	Dif_Intimacy	61760.417	1	61760.41	529.65	.000	.903
	Dif_Stress	68952.600	1	68952.60	628.30	.000	.917
Group	Dif_Cnflict	5905.033	2	2952.52	42.25	.000	.597
	Dif_Violence	12215.433	2	6107.72	285.99	.000	.909
	Dif_PersonalCom	7414.900	2	3707.45	127.28	.000	.817
	Dif_JoinCom	10098.900	2	5049.45	153.69	.000	.844
	Dif_FinMgt	447.633	2	223.82	2.12	.130	.069
	Dif_Intimacy	31932.033	2	15966.02	136.92	.000	.828
	Dif_Stress	34311.900	2	17155.95	156.33	.000	.846
Error	Dif_Cnflict	3982.900	57	69.875			
	Dif_Violence	1217.300	57	21.356			
	Dif_PersonalCom	1660.350	57	29.129			
	Dif_JoinCom	1872.750	57	32.855			
	Dif_FinMgt	6031.350	57	105.813			
	Dif_Intimacy	6646.550	57	116.606			
	Dif_Stress	6255.500	57	109.746			
Total	Dif_Cnflict	24056.000	60				
	Dif_Violence	34564.000	60				
	Dif_PersonalCom	20419.000	60				
	Dif_JoinCom	26667.000	60				
	Dif_FinMgt	9839.000	60				
	Dif_Intimacy	100339.000	60				
	Dif_Stress	109520.000	60				

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APPENDIX D-4

Pairwise Comparison of Experimental Conditions for Dimensions of Marital Distress

Dependent Variable	(I) Group	(J) Group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval for Difference Lower Bound	Upper Bound
Dif_Cnflict	CBT	IBCT	-12.250*	2.643	.000	-18.770	-5.730
		CTL	12.050*	2.643	.000	5.530	18.570
	IBCT	CBT	12.250*	2.643	.000	5.730	18.770
		CTL	24.300*	2.643	.000	17.780	30.820
	CTL	CBT	-12.050*	2.643	.000	-18.570	-5.530
		IBCT	-24.300*	2.643	.000	-30.820	-17.780
Dif_Violence	CBT	IBCT	-17.650*	1.461	.000	-21.255	-14.045
		CTL	17.300*	1.461	.000	13.695	20.905
	IBCT	CBT	17.650*	1.461	.000	14.045	21.255
		CTL	34.950*	1.461	.000	31.345	38.555
	CTL	CBT	-17.300*	1.461	.000	-20.905	-13.695
		IBCT	-34.950*	1.461	.000	-38.555	-31.345
Dif_PerslCom	CBT	IBCT	-16.850*	1.707	.000	-21.060	-12.640
		CTL	10.100*	1.707	.000	5.890	14.310
	IBCT	CBT	16.850*	1.707	.000	12.640	21.060
		CTL	26.950*	1.707	.000	22.740	31.160
	CTL	CBT	-10.100*	1.707	.000	-14.310	-5.890
		IBCT	-26.950*	1.707	.000	-31.160	-22.740
Dif_JoinCom	CBT	IBCT	-23.100*	1.813	.000	-27.571	-18.629
		CTL	7.350*	1.813	.000	2.879	11.821
	IBCT	CBT	23.100*	1.813	.000	18.629	27.571
		CTL	30.450*	1.813	.000	25.979	34.921
	CTL	CBT	-7.350*	1.813	.000	-11.821	-2.879
		IBCT	-30.450*	1.813	.000	-34.921	-25.979
Dif_FinMgt	CBT	IBCT	-4.250	3.253	.590	-12.274	3.774
		CTL	2.350	3.253	1.00	-5.674	10.374
	IBCT	CBT	4.250	3.253	.590	-3.774	12.274
		CTL	6.600	3.253	.141	-1.424	14.624
	CTL	CBT	-2.350	3.253	1.00	-10.374	5.674

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		IBCT	-6.600	3.253	.141	-14.624	1.424
Dif_Intimacy	CBT	IBCT	-23.450*	3.415	.000	-31.873	-15.027
		CTL	32.800*	3.415	.000	24.377	41.223
	IBCT	CBT	23.450*	3.415	.000	15.027	31.873
		CTL	56.250*	3.415	.000	47.827	64.673
	CTL	CBT	-32.800*	3.415	.000	-41.223	-24.377
		IBCT	-56.250*	3.415	.000	-64.673	-47.827
Dif_Stress	CBT	IBCT	-16.200*	3.313	.000	-24.372	-8.028
		CTL	40.650*	3.313	.000	32.478	48.822
	IBCT	CBT	16.200*	3.313	.000	8.028	24.372
		CTL	56.850*	3.313	.000	48.678	65.022
	CTL	CBT	-40.650*	3.313	.000	-48.822	-32.478
		IBCT	-56.850*	3.313	.000	-65.022	-48.678

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

APPENDIX D-5

Multivariate Tests

Effect		Value	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.998	2608.064[b]	8.000	35.000	.000
	Wilks' Lambda	.002	2608.064[b]	8.000	35.000	.000
	Hotelling's Trace	596.129	2608.064[b]	8.000	35.000	.000
	Roy's Largest Root	596.129	2608.064[b]	8.000	35.000	.000
Gender	Pillai's Trace	.270	1.615[b]	8.000	35.000	.156
	Wilks' Lambda	.730	1.615[b]	8.000	35.000	.156
	Hotelling's Trace	.369	1.615[b]	8.000	35.000	.156
	Roy's Largest Root	.369	1.615[b]	8.000	35.000	.156
Age	Pillai's Trace	.599	1.153	24.000	111.000	.301
	Wilks' Lambda	.498	1.158	24.000	102.112	.299
	Hotelling's Trace	.824	1.156	24.000	101.000	.301
	Roy's Largest Root	.502	2.320[c]	8.000	37.000	.040
Length of marriage	Pillai's Trace	.946	1.137	40.000	195.000	.280
	Wilks' Lambda	.304	1.219	40.000	155.356	.197
	Hotelling's Trace	1.557	1.300	40.000	167.000	.129
	Roy's Largest Root	.999	4.869[c]	8.000	39.000	.000
A1 * A2	Pillai's Trace	.554	1.725	16.000	72.000	.061

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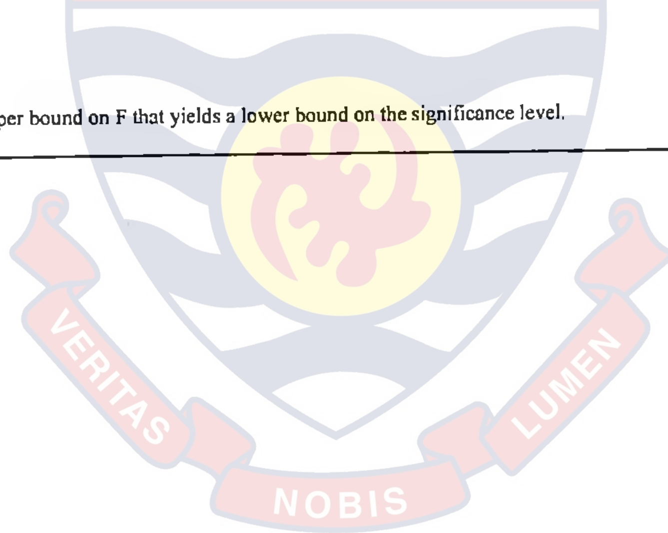
	Wilks' Lambda	.522	1.679[b]	16.000	70.000	.072
	Hotelling's Trace	.768	1.632	16.000	68.000	.084
	Roy's Largest Root	.414	1.865[c]	8.000	36.000	.097
A1 * A4	Pillai's Trace	.394	1.104	16.000	72.000	.368
	Wilks' Lambda	.640	1.092[b]	16.000	70.000	.380
	Hotelling's Trace	.508	1.079	16.000	68.000	.392
	Roy's Largest Root	.357	1.607[c]	8.000	36.000	.157
A2 * A4	Pillai's Trace	.537	1.652	16.000	72.000	.077
	Wilks' Lambda	.533	1.618[b]	16.000	70.000	.087
	Hotelling's Trace	.745	1.582	16.000	68.000	.098
	Roy's Largest Root	.456	2.050[c]	8.000	36.000	.068
A1 * A2 * A4	Pillai's Trace	.000	.[b]	.000	.000	.
	Wilks' Lambda	1.000	.[b]	.000	38.500	.
	Hotelling's Trace	.000	.[b]	.000	2.000	.
	Roy's Largest Root	.000	.000[b]	8.000	34.000	1.000

a. Design: Intercept + A1 + A2 + A4 + A1 * A2 + A1 * A4 + A2 * A4 + A1 * A2 * A4

b. Exact statistic

c. The statistic is an upper bound on F that yields a lower bound on the significance level.



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