Pakistan Journal of Psychology, December 2014, 45, 2, 37-58

EFFECTIVENESS OF COGNITIVE BEHAVIORAL COUPLE THERAPY IN PAKISTANI COUPLES WITH MARITAL DISSATISFACTION

Samia Farrukh, Zainab F. Zadeh*, & Zainab Hussain Bhutto
Institute of Professional Psychology, Bahria University Karachi Campus

ABSTRACT

This study was designed to evaluate the effectiveness of cognitive behavioral interventions with married couples experiencing marital dissatisfaction. The research design of the study was experimental. Fifty (50) married couples were randomly allocated into two equal groups: the experimental group (the couples received the treatment) and the control group (waited for behavioral interventions).Demographic information was obtained from participants in experimental and control groups. Both groups were assessed for marital adjustment by completing the Dyadic Adjustment Scale (DAS) and the Kansas Marital Satisfaction Scale (KMSS) before (pre-intervention) and after (post-intervention) the cognitive behavioral interventions. The cognitive marital techniques used in the study were adapted from Dattilio (1989). The data was analyzed by using MANOVA and t-tests for post-hoc comparisons. Findings of the study indicated that couples who received cognitive behavioral interventions showed significant reduction in marital dissatisfaction. Study findings have more important implication for the clinicians who are dealing with marital issues.

Keywords: Resolution of Marital Dissatisfaction, Pakistani Couples, Cognitive Behavioral Interventions

*Correspondence Address: Zainab F. Zaddeh, Ph.D. Director Institute of Professional Psychology, Bahria University, Karachi Campus (email: zainfz@yahoo.com)

INTRODUCTION

Marriage is a universal human activity which takes place in every society. Harmonious marital relationships are not only required for the psychological wellbeing of both the partners but for the progression of society as well. Disturbed and unsatisfying marital relations lead to increase emotional disturbances and chaos in marital life.

Marital satisfaction is defined as how affectionately an individual feels about his/her marriage (Diener, Sandvik, & Pavot, 1991). This is intricately woven with one's psychological health (Horwitz, Mc Laughlin, & White, 1998). Those who have found happiness and peace in their marriage, are said to have better immunity (Kiecolt-Glaser & Newton, 2001) and their sexual lives are also more active than the unmarried population (Laumann, Gagnon, Michael, & Michael, 1994) and this lead to decrease in the rate of divorce among couples (White & Booth, 1991). Satisfied couples think about their relationship and its maintenance as a shared challenge and express a sense of shared goals, affection, commitment and respect within the relationship (Carrere, Buehlman, Gottman, & Ruckstuchl, 2000). In contrast, distressed couples focus on their individual desire and express dissatisfaction and sense of chaos in their married life.

Marital dissatisfaction on the other hand is associated with employing more negative and less positive techniques to solve conflicts (Coyne, Thompson, & Palmer, 2002); giving an external form to these behaviors in off springs (Lindhal & Malik, 1999) and negatively influencing immune defenses (Dopp, Miller, Myers, & Fahey, 2000). Moreover, destructive behaviors and patterns are more regularly and vehemently expressed by couples facing marital dissatisfaction, than those who feel satisfaction in their marriage (Gottman & Notarius, 2000). According to Gottman and Levenson (1992) gave a flow representation in the form of cascade where couples who were not satisfied in marriage tend to be more angry, narcissistic and criticizing in comparison to those who exhibit marital bliss. The former group shows cases constructive patterns based on a mutual sense of agreement backed up by validation and enacted upon in compliance.

Many couples manage these disagreements among themselves without having any serious implications on their marital life. On the other hand, some couples see a continual deterioration of their marital happiness, when these destructive interactions are stretched and revisited over a period of time. Since

social life is structured differently in the East and West, the reasons for marital bliss are also different from one another. Available literature on this issue suggest that in Pakistani society feelings of marital satisfaction and dissatisfaction depends on a number of socio-cultural factors e.g. education of women (Dawood & Farooqui, 2000); family system (Whiting & Whiting, 1975); marriage being arranged or love, whether women is working or not working (Zadeh & Ahmad, 2007), socioeconomic status (Munaf & Ahmed, 1999); gender differences (Ayub & Iqbal, 2012). Married women in Pakistani society due to scarcity of resources remain in conflict with husbands and in-laws and this increases their dissatisfaction (Qadir, De Silva, Prince, & Khan, 2005). Marital dissatisfaction can do no good to anyone. Whenever there is a conflict or disagreement in the relationship, its impact is not only disastrous for the couples themselves but for the society at large. Marital problems call for urgent solution.

In Pakistani society, most of the time marital issues are either resolved by elder family members or through close common friends in a non-professional way. Couples do seek therapy when there is a strong fear that marriage is going to end in divorce. So in deep crisis professional help is needed. Marital therapy in Pakistan is still in infancy. This issue is of great importance for professionals working to enhance marital satisfaction among distressed couples in Pakistani society. Recently there has been an increasing trend among Pakistani couples with marital dissatisfaction seeking help for marital dysfunction to seek professional help. To deal with this issue, Pakistani mental health professionals have been utilizing a variety of techniques including marital counseling, marital therapy, marriage and family therapy, and most recently cognitive behavior therapy (CBT).

The aim of cognitive behavioral interventions in marital dissatisfaction is to decrease aversive interactions and to increase positive interactions among couples that contribute to the perception of one another's behaviors. Change in cognitive thought processes and emotions can be both a pre-requisite for and consequently a positive change in behavior of the partners can be evaluated during therapeutic processes (Epstein & Baucom, 1998). Unfortunately most of the outcome studies on cognitive behavioral interventions have been conducted in Europe and North America, and very little literature is available on the efficacy of cognitive-behavioral interventions with couples from underdeveloped or third world countries. Ahmadi et al. (2009) suggested that effectiveness of CBT was significant both for veterans themselves and their spouses. According

to Khalid and Kausar (2003), use of conflict resolution is an important factor in marital satisfaction.

The study was designed to investigate the effectiveness of cognitive-behavioral interventions based on the therapeutic guidelines provided by Dattilio in 1989. Pakistan is different from the western world both in terms of standards of life and culture. This research was an attempt to scientifically test out the generalization of findings from one culture to another and the focus was on evidence-based clinical practice. Cognitive behavioral interventions for reducing marital dissatisfaction refers to therapy sessions that focuses on the client/ his or her partner, and their interpersonal relationship at the same time helping the spouses; to become more active observers in evaluation of their own cognitions so that their emotional and behavioral responses to one another would be minimally affected by their distorted cognitions. In other words, the main goal of these techniques is to bring a change in thinking processes of both partners which is pre-requisite for bringing about a change in their behaviors and emotions. This change can be evaluated during therapeutic process (Epstein & Baucom, 1998).
Cognitive marital therapy has been subjected to more controlled outcome studies than any other marital therapeutic modality and there is substantial empirical evidence that cognitive behavioral interventions reduce marital distress (Epstein & Baucom, 2002; Dattilio & Epstein, 2003).Therefore, it was hypothesized Couples who received cognitive-behavioral interventions would score high on all the dimensions of Dyadic Adjustment Scale, and Couples who received cognitive-behavioral interventions would score high on both Dyadic Adjustment Scale and Kansas Marital Satisfaction Scale, than the couples who did not receive the interventions.

METHOD

The study was performed as an experimental research design. In the study cognitive behavioral interventions were used in the experimental group and waiting list was used as control group. Data was collected through standardized, structured self-report questionnaires of the Dyadic Adjustment Scale (Spanier, 1976) and Kansas Marital Satisfaction scale (Grover, Paff-Bergen, Russell, & Schumm, 1984). The English version of both the scales was utilized and the educational criterion of the sampled population was minimum intermediate level.

Participants

The participants of the present study were selected through purposive sampling from a pool of couples referred by psychiatrists practicing in Karachi to the Institute of Professional Psychology, Bahria University for marital therapy. Purposive non-random sampling technique was chosen for the present study. The ages of the couples ranged from 25 to 55 years and married for at least three years to avoid honeymoon effect.

A total of 50 couples were selected and randomly assigned into 2 groups (each group consisting of 25 couples): the treatment group (couples receiving cognitive-behavioral interventions) and the control group (couples on waiting list for treatment). After the selection each couple met with the principal investigator. Demographic information about each participant in both (experimental and control) groups in relation to educational level, number of children, number of years married was obtained. Principal investigator assessed the couples on the following exclusionary criteria:

a. Any of the Axis I DSM-IV-TR (APA; American Psychiatric Association, 2000) psychiatric disorders
b. Substance abuse or alcohol dependence
c. Mental retardation
d. Any of the DSM-IV-TR (APA, 2000) Axis II personality disorders
e. Couples or partner on psychotropic medication
f. Severe domestic violence, emotional abuse, or sexual abuse
g. Battered wife syndrome
h. Couples who had received previous behavioral interventions

Measures

Dyadic Adjustment Scale (DAS)

The Dyadic Adjustment Scale (DAS) is a revised version of the Locke-Wallace Marital Adjustment Test (Spanier, 1989). It is a 5-point Likert self-rating scale, consisting of 32 items categorized into 4 subscales: (1) Dyadic Consensus, (2) Affectional Expression, (3) Dyadic Cohesion, and (4) Dyadic Satisfaction.

The DAS has demonstrated coefficients of overall DAS score .96; Dyadic consensus .90; Dyadic satisfaction .94, Dyadic Cohesion .90 and Affectional Expression .73 (Spanier, 1976; Spanier & Lewis, 1980). Filisinger (1983) found similar reliability coefficients and, furthermore, provided strong evidence for content validity from independent judges, who examined the items. Spanier (1976) and Filisinger (1983) suggested a cut off score of 100 to differentiate between distressed and non-distressed couples. For the study conducted, reliability coefficient for overall DAS was good with an alpha of .87.

Kansas Marital Satisfaction Scale (KMSS)

Kansas Marital Satisfaction Scale (KMSS) is used as an assenting scale of the Dyadic Adjustment Scale (DAS). The KMSS was developed by Grover, Paff-Bergen, Russell, and Schumm (1984) in response to the theoretical comments made by Spanier and Cole (1976) with regard to the conceptual differences between questions on spouses, marriage and marital relationship. KMSS is a brief (3-items) instrument and attempts to measure the overall satisfaction of partners with regard to their relationship. Crane, Middleton and Bean (2000) suggested a cut off score of 17 to differentiate between satisfied and dissatisfied couples. The KMSS has excellent internal consistency for a short scale, with an alpha of .93 (Corcoran & Fischer, 1968). The KMSS also has relatively consistent concurrent validity, significantly correlated with the Dyadic Adjustment Scale (Corcoran & Fischer, 1968). For the current study, internal consistency is very good with an alpha of .90.

Procedure

Initial contact has been established with the psychiatrist practicing in various hospitals of Karachi. The purpose of the study was explained. Thus psychiatrists and psychologists cooperated in referring couples who were showing marital dissatisfaction and who were eager to seek professional help as well. Each couple was required to sign a consent form to participate in the study. Couples were informed that cooperation was vital and they should have a genuine desire to modify or change their dysfunctional marital behaviors. Moreover, honesty and emotional openness were necessary for the treatment to be successful. However, the participation in the study was voluntary and they had the right to withdraw from study at any stage of the research..

The CBCT protocol included 12 sessions base on the guideline provided by Datillio (1989) and all the sessions were conducted by the principal investigator. The first session focused on detailed assessment of the problem and conflict areas as well as information was provided to the couples about the effectiveness of cognitive behavioral interventions in resolution of marital conflict. In the second session the main focus was on the use of measurement instrument. Qualitative feedback was given to the couples about the result and further education was provided about the efficacy of behavioral interventions in resolving marital dispute. These instruments provide the therapist; within relative short time with information about similarities and differences in the partners' attitudes, beliefs, and perceptions regarding various aspects of the relationship.

The third session was conducted with each spouse independently to tab his or her dysfunctional belief system with special emphasis on will to work in collaboration with the therapist. Subsequently, in the fourth session, information was provided on the conceptualization of couples problems. Discussion was primarily focused on the partners' motivation to change and review of their realistic or unrealistic expectations about marital satisfaction. The aim of the fifth session was to make couples draw a link between emotions and their dysfunctional thought processes and maintenance of dysfunctional thought record daily. In the sixth session couples were helped to challenge their own belief system by looking for evidence for and against dysfunctional records. Emphasis was placed on maintenance of thought diary during therapy. In the seventh session spouses were asked to write down separately their dysfunctional thoughts resulting emotions and behaviors at home. These strategies helped each partner choose his ways in modification of his or her negative style of thinking processes, behavior and affect in service of enhancing his or her relationship satisfaction.

The aim of the eight sessions was to increase the communication skills of both partners by expressing their thoughts and emotions clearly and sending of constructive rather than destructive messages to each other. Also rules for the speaker and for the listener were distributed to improve spouses' communication skills. The focus of the ninth session was on couples' specific problem areas and generation of possible set of solutions and their implementation. In the tenth session considerable therapeutic work was done to bring behavior change through mutual agreement. This was achieved by pursuing some common interests, activities together and to keep a record of that positive change.

The eleventh session was an extension of the last session. Previously learned positive behaviors were consolidated. The last session concentrated on what was achieved during the therapeutic process. Again measurement instruments were distributed by the researcher to assess overall marital satisfaction achieved through the usage of cognitive behavioral interventions.

The statistical package for social sciences, SPSS version 17.0 was employed to analyze the data. The statistical methods used for the analysis of the data in the present study were descriptive statistics, MANOVA and paired sample t- test.

Demographic characteristic of the entire sample was presented for their age, spouse's age, and number of years married and number of children. The data was worked out through descriptive statistics including frequency, mean, standard deviation, minimum and maximum scores.

MANOVA and paired sample t-test were used to calculate the difference in the scores of Dyadic adjustment and Kansas marital satisfaction between two groups (experimental and control) pre and post therapy to show the effectiveness of cognitive behavioral interventions for reduction of marital dissatisfaction among Pakistani couples.

Ethical Consideration

The researchers developed an informed consent form for the participants to sign before they engage in the research. This form acknowledged that the rights of the participants would be protected during the research. The right to participate was voluntary and they could withdraw from participation in the study at any stage and without any negative consequences.

The purpose of the study was explained to the participating couples and its likely impact on them. All questionnaires and therapeutic interventions given to the participants would be kept in strict confidentiality. The couples in the control group were assured that they would also receive therapeutic interventions after the completion of the research. Signatures of both the participants and the researcher were obtained agreeing to above mentioned provisions.

RESULTS

The obtained results provide the evidence that cognitive behavioral interventions were effective in reducing marital dissatisfaction among Pakistani couples. Descriptive statistics (mean, standard deviation, minimum and maximum values) of the variables were also calculated.

Table 1 and 2reveals the demographic information of all the couples which are selected in experimental and control group and cognitive behavioral couple therapy was given to participants in experimental group. A sample of 25 couples is selected for the treatment group from which the average age of males is39.24 years with a standard deviation 8.383.The average age of their spouses is 35.20 years with standard deviation 8.436. The average number of years of marriage is 10.80 and the average number of children is 2.20. Also a sample of 25 couples is selected for the control group which consists of average age of males 41.64 with standard deviation 7.745. The average age of their spouses is 36.72 with standard deviation 7.068. The average number of years of marriage is 12.20. It is worthwhile noting here that the age range of sample is wide this is due to the fact that in Pakistan the age difference between couple varies from 3 to 10 years, in very few cases the couple is of the same age range, Moreover, due to lack of awareness, stigma attached to therapy/counseling and various other cultural barrier very few couples consented to participate in the study, considering the ground realities control related to age factor was kept constant by having same age variation in the control group and experimental group.

Table 1
Demographics of the Sampled Population of Experimental Group

Variables	*Min*	*Max*	*M*	*SD*
Age	28	53	39.24	8.383
Spouse's Age	25	50	35.20	8.436
No. of years married	3	26	10.80	7.594
No. of Children	1	4	2.20	1.225

Table 2
Demographics of the Sampled Population of the Control Group

Variables	*Min*	*Max*	*M*	*SD*
Age	28	51	41.64	7.745
Spouse's Age	25	51	36.72	7.068
No. of years married	3	26	12.20	7.205
No. of Children	1	4	2.08	1.352

The results in successive tables 3 & 4 indicate the descriptive statistics of before and after therapy in experimental and control group. It shows the comparison of therapy in experimental group and control group in case of Dyadic Adjustment Scale and it's all dimensions (subscales). Therefore, it can easily be concluded that all the values after therapy in experimental group are higher than the before therapy as compared to control group.

Table 3
Descriptive Statistics of Before and After Therapy Experimental Group

Descriptions	Before Therapy		After Therapy	
	M	*SD*	*M*	*SD*
Overall DAS	61.34	21.986	68.32	19.416
Dyadic Consensus	25.82	9.332	28.26	8.174
Affectional Expression	5.10	2.720	5.82	2.496
Dyadic Cohesion	7.74	3.663	8.42	3.156
Dyadic Satisfaction	23.08	7.679	25.82	7.119

Table 4
Descriptive Statistics of Before and After Therapy Control Group

Descriptions	Before Therapy		After Therapy	
	M	*SD*	*M*	*SD*
Overall DAS	54.38	24.032	54.70	24.574
Dyadic Consensus	20.76	9.925	20.90	10.124
Affectional Expression	4.48	2.964	4.42	3.004
Dyadic Cohesion	7.94	4.718	8.04	4.794
Dyadic Satisfaction	21.20	7.949	21.34	8.166

Table 5 represents the comparison of Dyadic Adjustment Scale of all the respondents before and after therapy of experimental and control group. The average score of the participants in experimental group is 6.58 with standard deviation 4.74 and t value for pre and post comparison in experimental group is 9.81(.000) which indicates significant differences in pre and post comparison with large effect size (*d*= 2.802) for experimental group. On the other hand comparison of control group pre and post indicate average score is 0.32 with standard deviation of 1.7 and *t* value is 1.281(*p*=.206) which indicates insignificant difference in pre and post scores of control group.

Table 5
Comparison of Dyadic Adjustment Scale of Therapy Experimental and Control Group

Condition	*M*	*SD*	*t*	*df*	*p*	*Cohen's d*
Experimental Group	6.58	4.74	9. 81	49	.000*	2.802
Control group	0.32	1.76	1.281	49	.206	0.366

p<.05

The table 6 shows the MANOVA for the comparison of dyadic adjustment after therapy (experimental and control groups) of the respondents to check the effect of therapy. Age and sex are considered as the source of variation.

The P-value for therapy experimental group is .024 which is significant at 5% level of significance, whereas P-value for control is .234 which is not significant.

Table 6
Effect of Therapy Experimental and Control Groups on Dyadic Adjustment Scale using MANOVA

	Condition After Therapy	*SS*	*df*	*MS*	*F*	*p*
Dyadic adjustment	Experimental Group	3382.844	3	1127.615	3.437	.024*
	Control Group	2598.027	3	866.009	1.476	.234

**p< .05*

The table 7 shows the comparison of Kansas Marital Satisfaction of all the respondents before and after therapy (experimental and control group). The average score of the experimental group is 1.620 with standard deviation of 0.725 and *t* value for experimental group is 15.793 for pre and post comparison with large effect size (4.512). On the other hand comparison of control group indicates average score (0.100) with standard deviation of 0.416 and t value is 1.698 (.096)which indicates insignificant difference.

Table 7
Comparison of Kansas Marital Satisfaction Scale for Experimental and Control Group

Condition	*M*	*SD*	*t*	*df*	*p*	*Cohen's d*
Experimental Group	1.620	0.725	15.793	49	.000*	4.512
Control Group	0.10049	0.416	1.698	49	.096	0.485

**p< .05*

Table 8 shows the MANOVA for the comparison of Kansas Marital Status after therapy (experimental and control group) of the respondents to check the effect of therapy. Age and sex are considered as the source of variation. The P-value for experimental group is .046 which is significant at 5% level of significance and P-value for control is .240 which is not significant at 5% level of significance.

Table 8
Effect of Therapy Experimental and Control Groups on Kansas Marital Satisfaction Scale using MANOVA

	Condition After therapy	*SS*	*df*	*MS*	*F*	*p*
Kansas Marital Satisfaction	Experimental Group	63.988	3	21.329	2.881	.046*
	Control Group	50.547	3	11.595	1.453	.240

**p<.05*

DISCUSSION

It is a well known fact that 60% of the world's population live in Asia and most of the Asian people live in rest of the world. In this rapidly globalizing world, it is therefore imperative for couple therapists and researchers to know what is happening in marriage in the other side of the world. Cross cultural treatment outcome research is clearly needed in an Asian society where social and cultural values are different from western societies in which individualistic values are emphasized upon (Baucom, Epstein & Stantons, 2006; Datillio, 2010).

Asian societies like their western counterparts are also highly receptive for cognitive behavioral interventions used to reduce marital dissatisfaction. Therapeuitc techniques that lay emphasis on conflict management, positive exchange of behaviors, personal care, attentive and empathetic behavior, helpful

and supportive actions, show of respect for partners and elders seems to work well with Asian couples (Halford & Simons 2005). Pakistan due to its unique geographical location enjoys excess to diverse cultures. The present research conducted add further to knowledge and understanding of how Pakistani society can become a counterpart along with other Asian societies in resolving marital issues by utilizing cognitive behavioral interventions.

Cognitive behavioral marital interventions are basically used to enhance partner's skills for identifying and changing dysfucntional thinking patterns as well as teaching skills for positive communication and to utilize problem solving skills in a constructive manner. Zadeh and Lateef (2012) also suggested that cognitive behaviroal interventions are effective in dealing with depressvie symtoms in Pakistani young women. The educational and skill oriented aspects of these interventions are well envisioned to bring a positive shift in a dissatisfactory relationship within a brief time period.The focus in therapy was on the change in thinking process which involves weighing the advantages and disadvantages of a particular cognition. This approach increases partners' awareness of the consequences of trying to live upto the standards that are unrealistic and inappropriate in real life circumstances.

Harmonious marital relationships are required not only for the psychological well being of both the partners but for the society as a whole. Unsatisfactory relations in married life can increase chaos and emotional disturbances. Dyadic adjustment is an everchanging process which can be measured on a continuum from a well-adjusted to mal-adjusted in marital life. Hypothesis was supported by the data and was evident through the results depicted in table 3 and 4 which indicated differences in mean and standard deviation of overall as well as each dimension of dyadic adjustment. It indicated that couples who received intervention showed improvement on each dimension and overall dyadic adjustment before and after therapy while the the couples who did not recieve intervention did not show any difference in the mean and standard deviation in pre and post scores.

Worst economic conditions in Pakistan has taken a toll on the finances of couples. It was noted during the therapeutic process that due to financial constraints and economic unstability, partners rarely find a common ground in handling financial issues. Career decisions relating to children and ones own self is also problematic issue. When couples were communicating with each other in our society, it was found that men tend to withdraw from the discussion and

engage in stone walling whereas women criticise and showed disrespect towards the partner.

Through the use of therapeutic processes with special attention been given to the communication training, empathetic listening, positive exchange of behaviors and problem solving strategies to enhance consensus among the partners on conflicting issues which eventually minimize the feelings of dissatisfaction.Improving couples' skills for verbalizing thoughts and expressing emotions as well as listening effectively to each other is one of the most common form of cognitive interventions used to enhance consensus among partners. Considerable therapeutic work was done on partners' strength and ability to tolerate feelings of distress and to enhanace skills for expressing emotions in a constructive way to built healthy relations. Negotiation on conflicting issues requires the ability to weigh alternative in a calm and collective way. Utilization of problem solving strategies proved to be very helpful in developing consensus among partners.

Activity scheduling is infact intend to diagnose dysfunction as well as to learn new behaviors. It is important in developing cohesiveness between partners and maintaining strong relationship. In our society, it has been noted that many at times couples report that feelings of love and belonging has been diminshed altogether.

During the inital stages of the therapy, couples were reluctant to discuss intimacy needs but as therapy progressed, partners felt secured in the therapeutic environment, discussions were frequently held during the therapy sessions what partners expect from each other. In our society, the need for succorance, intimacy and achievement were dominant between couples. Many a times, during therapeutic process, it was seen that one spouse wants to continue the relationship but the other wants to end it.

The result in tables 6, 7 & 8 clearly indicates that couples who receive cognitive behavioral interventions score high on both Dyadic Adjustment Scale and Kansas Marital Satisfaction Scale than the couples who did not receive the interventions. During the course of therapy the cognitive behavior techniques were utilized to increase overall marital satisfaction like restructuring of cognitive distortions, communication training, empathetic listening, positive exchange of behaviors and problem solving strategies to enhannce partner's overall satisfaction in their married lives. In Pakistani society divorce and

separation is still considered to be a taboo so before filing for divorce or separation it usually becomes imperative for couple and family members to seek professional help.

Working with those couples who see no hope in maintenance of relationships is quite a demanding task as the emotions are too high and cognitions too distorted. Here appropriate training in communicating style is neededd as a help line for couples discussing about important issues or problem solving interactions. The therapist task was to reduce spouse's feelings of hopelessness and to teach partners to behave more constructively towards each other. Revival of feelings of respect, admiration and gratitude was found to be most powerful therapeutic toolto restore feelings of intimacy and satisfaction among Pakistani couples.

It can be concluded that cognitive behaviroal interventions were effective in developing consensus, cohesion, satisfaction and affectional expression among couples who have recieved these interventions. No significant change however was found in the couples who did not receive these cognitve behavioral intervention. The research findings are consistent with the previous studies by the Gotman and Levenson (2002) and Datillio (2010). Outcome of these studies have tested the effects of cognitive restructuring, training in communication skills for expression and listening, usage of validation, training in problem solving and activity scheduling. Reviews of these studies have indicated that these interventions are effective in reduction of marital dissatisfaction and results in overall increase in relationship satisfaction.

Conclusion

As disruption tend to continue in married life among Pakistani couples; couples would be motivated to seek professional help to adress issues and problems in a professional setting. The help provide by marital therapist provides them insight into their conjugal problems and to help in evaluation ones own cognition so that emotional and behavioral responses to one another will be minimally effected by misformed cognitions. Cognitve interventions help clients to think clearly about the problems in marital life and utilize strategies to reslove issues which subsequently leads to reduction in marital dissatisfaction.Thus it can be safely concluded that cogntive behavrioral internvetions are effective in resolution of marital dissatisfaction in a sample of Pakistani couples.

Limitation of the Study

Present research has certain limitations which can be valuable to overcome in future research. Current study relies only on dyadic adjustment scale and Kansas marital satisfadction scale, other measures for assesment of marital dissatisfaction can be utilized in future studies which might be more fruitful and useful for clinician and researchers.Another limitation pertains to the generalization of the findings as the sample is taken from Karachi city only. The research can not be generalized to whole Pakistani population. Moreover, the sessions and assessments were conducted by principal investigater therefore there are chances of experimenter's bias. The present study only utilizes cognitive behaviroal interventions to reduce marital dissatisfaction. However, it is recommended that comparasion between cognitive mode of therapy can be compared with other modalities of treatment which are equally effective in reducing marital distress.

Recommendations for the Future Research

The present research can benefit from future refinements. In future a systematized research is needed in a cross-cultural context that highlights current and traditional hierarchies in marriage. The social and cultural variables need to be explored to see how Pakistani spousesresolve their individual aspirations and conflicts in this globilizing society. The research conducted on these above mentioned variables will have a valuable implication on success and stability of marriages in Pakistani society.Demographic variables like age, number of years marriage, socio-economic status of couples may be explored more in detail in more extensive study with larger number of smaple considered in the future researchIt is suggested that a large sample size be adapted to confirm and validate the findings of the present research.

Implications of the Study

The findings of the present study has important clinical implications in understanding the nature of marital dissatisfaction among Pakistani couples. Mapping theterritory of distress offers clinicans and therapists the opportunity to work on specific "targets" and to intervene most efficiently. Research help the therapists to expereience the process of change in therapy when working with dissatisfied couples, clinicians seems to be taking part in a more collabortive stance with their respective clients. This research was an attempt to minimize the

gap between clinician and researcher. It enables the clinician to use research as a powerful tool in clinical practice.

REFERENCES

Ahmadi K., Karami, G., Noohi, S., Mokhatari, A., Gholamparo, H., & Rahim, A. (2009). The efficacy of cognitive behavior couple's therapy on marital adjustment of PTSD-diagnosed combat veterans. *Europe's Journal of Psychology, 2,* 31-40.

American Psychiatric Association.(2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision). Washington, DC: Author.

Ayub, N., & Iqbal, S. (2012). The factors predicting marital satisfaction: A gender difference in Pakistan. *International Journal of Interdisciplinary Social Sciences, 6*(7), 63-74.

Baucom, D. H., Epstein, N. B., & Stanton, S. (2006). The treatment of relationship distress: Theoretical perspectives and empirical findings. In D. Perlman & A. L. Vangelisti (Eds.), *Handbook of personal relationships* (pp. 745-765). Cambridge University Press.

Carrere, S., Buehlman, K. T., Gottman, J. M., & Ruckstuchl, L. (2000). Predicting marital stability and divorce in newlywed couples. *Journal of Family Psychology, 14*(1), 42-58.

Coyne, J. C., Thompson, R., & Palmer, S. C. (2002). Marital quality, coping with conflicts, marital complaints, and affection in couples with a depressed wife. *Journal of Family Psychology, 16,* 26–37.

Corcoran, K., & Fischer, J. (1968). *Measures for Clinical Practice*. New York: The free press.

Crane D. R., Middleton, K. C., & Bean, R. A. (2000). Establishing criterion scores for the Kansas Marital Satisfaction Scale and the revised Dyadic Adjustment Scale. *American Journal of Family Therapy, 28,* 53-60.

Dattilio, F. M. (1989). A guide to cognitive marital therapy. In P. A. Keller & S. R. Heyman (Eds.), *Innovations in clinical practice: A source book* (Vol. 8, pp. 27-42). Sarasota, FL: Professional Resource Exchange.

Datillio, F. M. (2010). *Cognitive-Behavioral therapy with Couples and Families: A comprehensive guide for clinicians.* New York: The Guilford Press.

Dattilio, F. M., & Epstein, N. B. (2003).Cognitive-behavioral couple and family therapy. In T. L. Sexton, G. R. Weekes & M. S. Robbins (Eds.) (pp. 147-175). *The family therapy handbook.* New York: Routledge.

Dawood, S., & Farooqi, S. (1997). Impact of females' education on their marital adjustment. *Pakistan Journal of Psychology, 28*(1-4), 27-37.

Diener, E., Sandvik, E., & Pavot, W. (1991). Happiness is the frequency, not the intensity of positive versus negative affect. In F. Strack, M. Argyle & N. Schwarz (Eds.), *Subjective well-being: An interdisciplinary perspective.* (pp. 119-140). Oxford: Pergamon Press.

Dopp, J. M., Miller, G. E., Myers, H. F., & Fahey, J. L. (2000) Increased natural killer-cell mobilization and cytotoxicity during marital conflict. *Brain, Behavior and Immunity*, *14*, 10-26.

Epstein, N. B., & Baucom, D. H. (1998).Cognitive-behavioral couple therapy. In F.M. Dattilio (Ed.), *Case studies in couple and family therapy: Systemic & cognitive perspectives* (pp. 37-61). New York: Guilford.

Epstein, N., & Baucom, D. H. (2002). *Enhanced Cognitive-behavior therapy for couples: A contextual approach*. Washington DC: American Psychological Press.

Epstein, N. B., & Baucom, D. H. (2003). Couple therapy. In R. L. Leahy (Ed.), *Roadblocks in cognitive-behavioral therapy: Transforming challenges into opportunities for change* (pp. 217-235). New York: Guildford Press.

Filisinger, E. E. (1983). *Marriage and family assessment: A sourcebook for family therapy*. Beverly Hills: Sage

Gottman, J. M., & Levenson, R. W. (1992). Marital processes predictive of later dissolutions: Behavior, physiology and health. *Journal of Personality and Social Psychology, 63,* 221-233.

Gottman, J. M., & Levenson, R. (2002). A two-factor model for predicting when a couple will divorce: Exploratory analyses using 14 years longitudinal data. *Family Process, 41,* 1, 83.

Gottman, J. M., & Notrious, C. I. (2000) Decade review: observing marital interaction. *Journal of Marriage and the Family, 62,* 927-947.

Grover, J., Paff-Bergen, L. A., Russell, C. S., & Schumm, W. R. (1984). The Kansas Marital Satisfaction Scale: A Brief Report. *Psychological Reports*, *54,* 629-630.

Halford, W. K., & Simons, M. (2005). Couple relationship education in Australia. *Family Process, 44* (2), 147–159.

Horwitz, A. V., Mc Laughlin, J., & White, H. R. (1998). How the negative and positive aspects of partner relationships affect the mental health of young married people. *Journal of Health and Social Behavior*, *39,* 124-136.

Khalid, R., & Kausar, R. (2003). Relationship between conflict resolution strategies and perceived marital adjustment. *Journal of Behavioral Sciences, 14*(1-2), 29-42.

Kiecolt-Glaser, J. K., & Newton, T. L. (2001). Marriage and health: His and hers. *Psychological Bulletin*, *127,* 472-503.

Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michael, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago: University of Chicago Press.

Lindhal, K. M., & Malik, N. M. (1999). Marital conflict, family processes and boys externalizing behavior in Hispanic Americans and European American families. *Journal of Clinical Psychology, 28,* 12-24.

Munaf, S., & Ahmed, R. (1999). Psychological effects of paid work on married women. *Pakistan Journal of Psychology, 30*, 59-74.

Qadir, F., De Silva, P., Prince, M., & Khan, M. (2005). Marital satisfaction in Pakistan: A pilot investigation. *Sexual and Relationship Therapy, 20,* 195-209.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, *38*(1), 15-29.

Spanier, G. B. (1989). *Dyadic Adjustment Scale.* Multi-Health System Inc.: USA.

Spanier, G. B., & Cole, C. L. (1976). Toward clarification and investigation of marital adjustment. *International Journal of Sociology of the Family, 6,* 121-146.

Spanier, G. B., & Lewis, R. A. (1980). Marital quality: A Review of the seventies. *Journal of Marriage and the Family*, *42*, 825-840.

White L. K., & Booth, A. (1991).Divorce over the life course: the role of marital happiness. *Journal of Family Issues*, *12*, 5-21.

Whiting, B. B., & Whiting, J. W. (1975). *Children of six cultures: A psycho-cultural Analysis.* Cambridge, MA: Harvard University Press.

Zadeh, F. Z., & Ahmad F. Z. (2007). Success of love and arranged marriages in working women of Karachi. A comparative study. *Pakistan Journal of Psychology, 38*(2), 15-24.

Zadeh, F. Z., & Lateef, M. (2012). Effect of cognitive behavioral therapy on depressed female university students of Karachi. *Procedia-Social and Behavioral Sciences, 69,* 798-806. Retrieved from: www.elsevier.com/locate/procedia.