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Comparison of the Effectiveness of Group Reality Therapy and Group Cognitive-Behavioral Hypnotherapy on Distress Tolerance and Marital Intimacy in Couples

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ABSTRACT

The present study aimed to compare the effectiveness of group reality therapy and group cognitive-behavioral hypnotherapy on distress tolerance and marital intimacy in couples. This study employed a quasi-experimental pretest-posttest design with a control group and a two-month follow-up. The statistical population included all couples aged 25 to 45 years who referred to Dr. Mehdi Pour-Asghar Psychology Clinic in Sari, Iran, during 2024–2025. The study sample consisted of 45 couples selected through purposive sampling based on the inclusion and exclusion criteria and randomly assigned equally to three groups using simple randomization. Data were collected using the Distress Tolerance Scale developed by Simons and Gaher (2005) and the Marital Intimacy Questionnaire developed by Bagarozzi (2001). The obtained data were analyzed using mixed repeated-measures analysis of variance in SPSS version 26. The results indicated a significant difference between the reality therapy experimental group and the cognitive-behavioral hypnotherapy experimental group in the scores of distress tolerance and marital intimacy ($p < .01$). Reality therapy produced greater changes in marital intimacy, whereas cognitive-behavioral hypnotherapy produced greater changes in couples' distress tolerance. In addition, the difference between the posttest and follow-up stages was not significant, indicating the stability of the treatment effects. Therefore, both approaches compared in this study can be used to promote couples' mental health.

Keywords: Distress tolerance, marital intimacy, reality therapy, cognitive-behavioral hypnotherapy, couples.

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Introduction

Marital relationships constitute one of the most important interpersonal systems in adult life and play a central role in psychological well-being, emotional regulation, interpersonal adjustment, and family functioning. The quality of marital interaction is not limited to the absence of conflict; rather, it reflects the couple's capacity to communicate effectively, regulate emotional tension, experience mutual closeness, and maintain adaptive patterns of support under stressful conditions. In contemporary couple and family psychology, marital health is increasingly understood as a multidimensional construct that includes satisfaction, adjustment, intimacy, resilience, sexual communication, emotional security, and the ability to tolerate relational distress. When couples are unable to manage emotional discomfort, disagreements may

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become chronic, intimacy may decline, and the marital relationship may gradually become vulnerable to emotional distance, dissatisfaction, betrayal, aggression, or psychological maladjustment. Accordingly, the development and evaluation of evidence-based couple interventions have become a major priority in clinical and counseling psychology. Recent evidence also indicates that couple-based interventions can improve important clinical and relational outcomes, even in populations affected by severe psychological distress, demonstrating the broader therapeutic value of dyadic and relationship-oriented approaches (1).

Among the key psychological variables involved in marital functioning, distress tolerance has received growing attention. Distress tolerance refers to the perceived and actual capacity to endure negative emotional states without resorting to impulsive, avoidant, aggressive, or maladaptive responses. In marital contexts, distress tolerance enables individuals to remain emotionally present during disagreement, tolerate frustration, delay reactive responses, and engage in more constructive communication. Low distress tolerance, by contrast, may intensify emotional reactivity, defensive communication, withdrawal, criticism, and conflict escalation. Couples with poor distress tolerance may interpret normal relational stressors as unbearable, uncontrollable, or threatening, which can reduce their ability to solve problems and maintain emotional connection. The importance of distress tolerance in couple functioning has been highlighted in intervention studies showing that therapeutic approaches can improve emotional regulation, communication patterns, and distress-related outcomes among couples experiencing relational difficulties (2, 3).

Marital intimacy is another core indicator of relationship quality and represents the degree of closeness, emotional connection, mutual understanding, trust, affection, and shared experience between partners. Intimacy is not a single-dimensional experience; it includes emotional, psychological, intellectual, physical, sexual, spiritual, aesthetic, and recreational-social components. Emotional intimacy refers to the ability to share feelings and receive empathic responses, while psychological intimacy involves mutual understanding of inner experiences and personal vulnerabilities. Sexual and physical intimacy reflect embodied dimensions of closeness, whereas intellectual, spiritual, aesthetic, and recreational-social intimacy involve shared values, meanings, interests, and experiences. A decline in intimacy may lead to alienation, emotional divorce, sexual dissatisfaction, and marital instability. Conversely, improvement in intimacy can strengthen marital satisfaction, commitment, adaptive communication, and relational resilience. Research has shown that couple therapy approaches, especially cognitive-behavioral and reality-therapy-based interventions, can improve marital intimacy and the overall quality of marital relationships (4, 5).

The relationship between distress tolerance and marital intimacy is theoretically and clinically important. Intimacy requires the capacity to remain open, vulnerable, and responsive in emotionally demanding interactions. Partners who cannot tolerate distress may avoid difficult conversations, become emotionally flooded, or respond with hostility, thereby reducing opportunities for closeness and repair. In contrast, greater distress tolerance may allow partners to listen more carefully, regulate negative affect, and remain engaged in relational problem-solving. Therefore, distress tolerance can be viewed as a regulatory foundation for intimacy, while intimacy itself may serve as a protective relational resource that reduces emotional threat and promotes security. This bidirectional connection suggests that interventions targeting either emotional regulation or relational responsibility may produce meaningful changes in couple functioning. Studies on marital satisfaction, adjustment, communication skills, resilience, and intimacy

consistently support the relevance of therapeutic interventions that address both individual self-regulation and dyadic interaction patterns (6-8).

Reality therapy, developed within the framework of choice theory, is one of the therapeutic approaches that has been applied to marital and family problems. This approach emphasizes personal responsibility, internal control, effective choice, present-focused evaluation, and the satisfaction of basic psychological needs through responsible behavior. From the perspective of reality therapy, many relational difficulties are maintained by external control psychology, blaming patterns, ineffective choices, and attempts to control the partner rather than evaluating one's own behavior. In couple therapy, reality therapy encourages partners to examine what they want from the relationship, what they are currently doing, whether their behaviors are effective, and how they can make more responsible and constructive choices. Through this process, couples may become more capable of replacing coercion, criticism, withdrawal, and resentment with commitment, communication, negotiation, and need-satisfying behaviors. Therefore, reality therapy is especially relevant for enhancing marital intimacy because it directly addresses responsibility, relational choice, and the quality of interpersonal connection.

Empirical findings have supported the usefulness of reality therapy in marital contexts. Reality therapy based on choice theory has been shown to improve marital intimacy and marital satisfaction, suggesting that increased responsibility and more effective behavioral choices may enhance closeness between partners (9). Similarly, Glasser's reality therapy has been found to influence marital satisfaction, life satisfaction, and communication skills among couples, indicating that this approach may improve both individual and relational dimensions of functioning (6). Reality-therapy-based couple therapy has also been reported to improve marital adjustment, emotional differentiation, and intimacy among couples experiencing emotional divorce, which is particularly important because emotional divorce often reflects a severe decline in intimacy despite the continuation of the formal marital relationship (5). In addition, comparative research has shown that reality therapy can be effective in improving marital satisfaction and self-control, and that it may be meaningfully compared with other structured interventions such as cognitive-behavioral therapy (10).

Reality therapy may also be relevant to distress tolerance because it promotes self-evaluation, responsibility, and internal control. When individuals attribute emotional discomfort entirely to external events or to the partner's behavior, they may feel helpless, reactive, and unable to regulate distress. Reality therapy shifts attention from external blame to personal choice and realistic action, thereby increasing perceived agency in emotionally difficult situations. This sense of agency may reduce helplessness and increase tolerance of relational tension. Evidence suggests that reality therapy can improve resilience and happiness in couples and may also influence distress tolerance in women referred to counseling centers (2, 7). Moreover, reality therapy has been applied beyond marital samples to reduce motivational problems, supporting its broader relevance as an intervention focused on choice, responsibility, and behavioral change (11). In couples exposed to violence, reality therapy has also been reported to improve emotion regulation and distress tolerance, further highlighting its potential value for emotionally dysregulated marital relationships (3).

Cognitive-behavioral hypnotherapy is another intervention approach that may be highly relevant to distress tolerance and marital functioning. This approach integrates cognitive-behavioral principles with hypnotic techniques such as relaxation, focused attention, imagery, suggestion, and cognitive rehearsal.

Cognitive-behavioral therapy focuses on identifying and modifying maladaptive thoughts, beliefs, interpretations, and behavioral responses, while hypnotherapy may enhance receptivity to therapeutic suggestions, reduce physiological arousal, and facilitate experiential learning. In combination, cognitive-behavioral hypnotherapy can help individuals recognize distress-related automatic thoughts, modify dysfunctional appraisals, reduce emotional reactivity, and strengthen adaptive coping responses. Because distress tolerance is closely related to cognitive appraisal, emotional arousal, and perceived capacity to endure discomfort, this integrative intervention may be particularly suitable for improving the ability to tolerate distress in intimate relationships.

Previous studies have provided evidence for the effectiveness of cognitive-behavioral hypnotherapy and cognitive hypnotherapy in psychological and marital outcomes. Cognitive-behavioral hypnotherapy has been found to improve distress tolerance and reduce aggression among women with premenstrual dysphoric disorder, suggesting that this method can directly influence emotional endurance and behavioral control under conditions of heightened affective vulnerability (12). Similarly, cognitive-behavioral hypnotherapy has been shown to affect pain and emotion regulation, supporting its potential role in improving self-regulatory processes involved in distress management (13). In marital and sexual domains, cognitive hypnosis therapy has been reported to improve women's sexual desire and marital satisfaction, while cognitive hypnotherapy has also been found to influence body image and marital satisfaction among women (14, 15). These findings suggest that hypnotherapeutic methods, particularly when integrated with cognitive-behavioral principles, may contribute not only to individual emotional regulation but also to marital satisfaction and relational functioning.

Hypnotherapy has also been examined in relation to emotional control in people affected by marital infidelity, a context often characterized by intense distress, intrusive thoughts, anger, shame, and disruptions in trust and intimacy. Evidence indicating the effectiveness of hypnotherapy and schema therapy in improving emotional control among individuals affected by marital infidelity suggests that hypnotic interventions may help individuals regulate intense emotional responses in relational crises (16). This is clinically important because couples experiencing severe relational distress often require interventions that address both cognitive-emotional dysregulation and relational reconstruction. Cognitive-behavioral hypnotherapy may therefore be especially useful for improving distress tolerance, while reality therapy may be particularly effective in strengthening intimacy through responsibility, choice, and behavioral commitment. The comparison of these two approaches can clarify whether a more self-regulatory and cognitively focused intervention or a more responsibility-oriented and relationally focused intervention produces stronger effects on specific couple outcomes.

Cognitive-behavioral couple therapy has also shown effectiveness in improving marital satisfaction, marital adjustment, relationship quality, marital intimacy, and marital depression. These findings are relevant because cognitive-behavioral hypnotherapy shares key mechanisms with cognitive-behavioral therapy, including cognitive restructuring, behavioral modification, emotional awareness, and skill development. Group couples therapy based on cognitive-behavioral therapy has been reported to improve marital satisfaction and adjustment, supporting the broader value of structured cognitive-behavioral methods in couple interventions (8). Likewise, group cognitive-behavioral couple therapy has been found to improve marital relationship quality, marital intimacy, and marital depression among betrayed women,

indicating that cognitive-behavioral methods can be effective even when marital distress is complicated by betrayal and emotional injury (4). These findings provide a strong rationale for examining an integrative cognitive-behavioral hypnotherapy approach in couples experiencing difficulties in distress tolerance and intimacy.

Another important consideration in marital intervention research is the dyadic and reciprocal nature of couple relationships. Variables such as consent, sexual communication, emotional responsiveness, and mutual respect are not merely individual traits but relational processes shaped by both partners. Research on sexual consent in committed relationships has emphasized the dyadic nature of intimate decision-making and the importance of communication, mutual understanding, and relational context in marital and committed partnerships (17). This perspective is consistent with the need to examine interventions that can improve both individual regulatory capacities and interpersonal intimacy. When couples learn to tolerate distress, communicate needs, and engage responsibly with each other, they are more likely to develop healthier relational patterns. Therefore, evaluating interventions at the couple level is essential for understanding how therapeutic change occurs within the marital system rather than only within isolated individuals.

Despite the existing evidence supporting reality therapy, cognitive-behavioral therapy, hypnotherapy, and couple-based interventions, several gaps remain. First, most previous studies have examined these approaches separately or compared them with other interventions, while fewer studies have directly compared group reality therapy with group cognitive-behavioral hypnotherapy in the same marital sample. Second, many studies have focused on broad outcomes such as marital satisfaction, adjustment, or happiness, whereas distress tolerance and multidimensional marital intimacy have received less comparative attention. Third, because reality therapy and cognitive-behavioral hypnotherapy are based on different mechanisms of change, their relative effectiveness may differ across outcomes. Reality therapy may be more powerful for improving intimacy because it directly targets responsibility, choice, commitment, and relational behavior, whereas cognitive-behavioral hypnotherapy may be more effective for distress tolerance because it targets cognitive appraisal, emotional arousal, and self-regulation. A direct comparison can therefore provide clinically useful evidence for selecting interventions according to couples' primary therapeutic needs.

Given the importance of distress tolerance and marital intimacy in couple functioning, and considering the theoretical and empirical support for both reality therapy and cognitive-behavioral hypnotherapy, the present study aimed to compare the effectiveness of group reality therapy and group cognitive-behavioral hypnotherapy on distress tolerance and marital intimacy among couples.

Methods and Materials

Study Design and Participants

The present study was applied in terms of its objective and employed a comparative quasi-experimental design with a pretest-posttest control group and a two-month follow-up. The design was considered comparative because the effectiveness of two therapeutic approaches, namely group reality therapy and group cognitive-behavioral hypnotherapy, was compared on the dependent variables of distress tolerance

and marital intimacy. The statistical population consisted of all couples aged 25 to 45 years who referred to Dr. Mehdi Pour-Asghar Psychology Clinic in Sari, Iran, during 2024–2025.

Considering the quasi-experimental nature of the study, the necessity of implementing psychological interventions, and the recommended sample size of 15 participants per group in quasi-experimental studies (Delavar, 2019), the sample size was also estimated using G*Power software. Based on a medium effect size of 0.25, a significance level of .05, and statistical power of .90, the minimum required sample size was estimated to be 13 couples per group. However, to account for possible attrition during the intervention and follow-up phases, 15 couples were assigned to each group. Accordingly, 45 couples were selected from among couples referring to the clinic through purposive sampling based on the inclusion and exclusion criteria and were then randomly assigned, using simple randomization, to three equal groups: the group reality therapy intervention group, the group cognitive-behavioral hypnotherapy intervention group, and the control group.

Data Collection

The Distress Tolerance Scale developed by Simons and Gaher (2005) was used to assess participants' ability to tolerate emotional distress. This scale consists of 15 items and includes four subscales: tolerance, which refers to tolerance of emotional distress; absorption, which reflects the extent to which individuals become absorbed by negative emotions; appraisal, which assesses the subjective evaluation of distress; and regulation, which refers to efforts made to regulate or reduce distress. The items are scored on a five-point Likert scale ranging from 1, indicating strongly agree, to 5, indicating strongly disagree. Item 6 is reverse-scored, and higher total scores indicate greater distress tolerance. In the original study by Simons and Gaher (2005), Cronbach's alpha coefficients for the subscales were reported as .72, .82, .78, and .70, respectively, and the alpha coefficient for the total scale was .82. Evidence also supported the initial criterion and convergent validity of the scale. In an Iranian validation study, Azizi et al. reported acceptable internal consistency for the total scale, with a Cronbach's alpha coefficient of .71, and moderate reliability coefficients for the subscales, including .54 for tolerance, .42 for absorption, .56 for appraisal, and .58 for regulation.

The Marital Intimacy Questionnaire developed by Bagarozzi (2001) was used to measure marital intimacy among couples. This questionnaire consists of 41 items and assesses intimacy needs across eight dimensions: emotional intimacy, psychological intimacy, intellectual intimacy, sexual intimacy, physical intimacy, spiritual intimacy, aesthetic intimacy, and recreational-social intimacy. The instrument provides a multidimensional assessment of intimacy in marital relationships and evaluates the extent to which partners experience closeness, mutual understanding, emotional connection, shared experiences, and interpersonal responsiveness within the marital bond. In the study by Houshmand (2012), the content validity of the questionnaire was confirmed by two university professors, and the instrument was subsequently administered to the target sample. The reliability of the questionnaire was assessed using Cronbach's alpha coefficient. Cronbach's alpha values range from 0, indicating lack of internal consistency, to +1, indicating perfect reliability; therefore, values closer to +1 indicate greater reliability of the questionnaire.

Interventions

The group reality therapy intervention was implemented for couples assigned to the first experimental group. This intervention was based on the principles of reality therapy and choice theory, with emphasis on

responsibility, internal control, effective choice, present-oriented evaluation, and the reconstruction of maladaptive interpersonal behaviors. During the group sessions, participants were guided to identify their basic psychological needs, examine the quality of their marital relationship, evaluate the effectiveness of their current behaviors, and develop more realistic and responsible plans for improving marital interactions. The therapeutic process focused on increasing awareness of personal choices, reducing blaming patterns, strengthening commitment to constructive behaviors, and enhancing intimacy through more effective communication, need satisfaction, and behavioral accountability within the marital relationship.

The group cognitive-behavioral hypnotherapy intervention was implemented for couples assigned to the second experimental group. This intervention integrated cognitive-behavioral techniques with hypnotherapeutic procedures to improve emotional regulation, cognitive flexibility, and distress tolerance. The sessions included psychoeducation about the relationship between thoughts, emotions, physiological arousal, and marital responses; identification and modification of dysfunctional beliefs; relaxation training; hypnotic induction; guided imagery; therapeutic suggestion; and cognitive rehearsal of adaptive coping responses. The intervention aimed to help couples recognize distress-related automatic thoughts, reduce emotional reactivity, strengthen self-regulation, and develop more adaptive responses to interpersonal stressors. Through the use of hypnotic and cognitive-behavioral strategies, participants were supported in increasing their capacity to tolerate emotional discomfort and respond more effectively to marital challenges.

The control group did not receive any psychological intervention during the active treatment phase of the study. Participants in this group completed the research instruments at the pretest, posttest, and two-month follow-up stages under the same assessment conditions as the two experimental groups. To observe ethical considerations, participants in the control group were informed that they could receive appropriate psychological services after the completion of the research process if needed. This procedure made it possible to compare changes in the experimental groups with the natural course of the dependent variables in the absence of intervention.

Data Analysis

The collected data were analyzed using SPSS version 26. Descriptive statistics, including mean and standard deviation, were used to summarize participants' scores on distress tolerance and marital intimacy across the pretest, posttest, and follow-up stages. To examine the effectiveness of the interventions and compare changes across time and groups, mixed repeated-measures analysis of variance was used. This analysis made it possible to evaluate the main effect of time, the main effect of group, and the time-by-group interaction effect for each dependent variable. Prior to conducting the inferential analyses, the required statistical assumptions, including normality of the score distributions, homogeneity of variances, and the assumption of sphericity, were examined. When the assumption of sphericity was violated, appropriate correction procedures were applied. The significance level for all inferential analyses was set at .05.

Findings and Results

The study sample consisted of 45 couples aged 25 to 45 years who had referred to Dr. Mehdi Pour-Asghar Psychology Clinic in Sari, Iran, during 2024–2025. Participants were assigned equally to three groups, with

15 couples in the group reality therapy group, 15 couples in the group cognitive-behavioral hypnotherapy group, and 15 couples in the control group. All participants completed the pretest, posttest, and two-month follow-up assessments. The demographic inclusion range indicated that all participants were adult couples in early to middle adulthood, and the equal group allocation provided a balanced structure for comparing the two therapeutic approaches with the control condition.

Table 1. Descriptive Statistics for Distress Tolerance and Marital Intimacy Across Groups and Measurement Stages

Variable	Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Follow-up M	Follow-up SD
Distress tolerance	Reality therapy	26.80	3.85	29.20	3.91	29.20	3.91
Distress tolerance	Cognitive-behavioral hypnotherapy	26.06	3.86	35.40	3.92	35.26	3.97
Distress tolerance	Control	25.06	3.67	24.86	3.73	24.73	4.06
Emotional intimacy	Reality therapy	12.33	1.91	17.00	1.77	17.00	1.81
Emotional intimacy	Cognitive-behavioral hypnotherapy	12.46	2.58	14.46	2.35	14.40	2.32
Emotional intimacy	Control	12.60	2.16	12.46	2.19	12.60	2.22
Psychological intimacy	Reality therapy	26.13	1.84	31.80	1.97	31.73	1.79
Psychological intimacy	Cognitive-behavioral hypnotherapy	24.66	1.34	26.00	1.46	25.93	1.43
Psychological intimacy	Control	25.46	1.68	25.40	1.80	25.33	1.44
Intellectual intimacy	Reality therapy	9.06	2.12	15.66	1.63	15.66	1.91
Intellectual intimacy	Cognitive-behavioral hypnotherapy	8.46	1.84	10.46	1.35	10.46	1.24
Intellectual intimacy	Control	8.40	1.72	8.60	1.54	8.60	1.68
Sexual intimacy	Reality therapy	33.06	1.57	40.86	2.13	40.80	2.13
Sexual intimacy	Cognitive-behavioral hypnotherapy	33.20	1.74	35.00	1.73	35.00	1.73
Sexual intimacy	Control	33.06	2.18	33.06	2.15	33.06	2.15
Physical intimacy	Reality therapy	27.40	2.13	33.93	2.18	33.93	2.05
Physical intimacy	Cognitive-behavioral hypnotherapy	27.93	2.91	30.86	4.77	30.86	4.82
Physical intimacy	Control	27.66	3.03	27.53	3.24	27.53	3.20
Spiritual intimacy	Reality therapy	17.40	2.38	23.13	2.03	23.06	2.15
Spiritual intimacy	Cognitive-behavioral hypnotherapy	18.20	2.48	20.06	2.43	20.13	2.44
Spiritual intimacy	Control	17.60	1.91	17.53	1.92	17.60	2.09
Aesthetic intimacy	Reality therapy	12.20	1.65	17.40	1.66	17.26	1.72
Aesthetic intimacy	Cognitive-behavioral hypnotherapy	11.46	1.80	13.20	1.89	13.20	1.78
Aesthetic intimacy	Control	11.73	1.79	11.80	1.42	11.80	1.52
Recreational-social intimacy	Reality therapy	36.60	2.79	44.40	2.16	44.46	2.03
Recreational-social intimacy	Cognitive-behavioral hypnotherapy	39.46	2.53	41.26	2.37	41.20	2.39
Recreational-social intimacy	Control	39.86	1.95	39.80	2.11	39.60	2.41

As shown in Table 1, the pretest mean scores of distress tolerance were relatively similar across the reality therapy, cognitive-behavioral hypnotherapy, and control groups. At posttest and follow-up, however, both intervention groups showed higher mean scores than the control group, with the largest increase observed in the cognitive-behavioral hypnotherapy group. Regarding marital intimacy, the pretest scores of most subscales were generally comparable across the three groups, although some baseline differences were observed in recreational-social intimacy. At posttest and follow-up, the reality therapy group demonstrated

higher scores than the cognitive-behavioral hypnotherapy and control groups across all marital intimacy subscales. The follow-up means were close to the posttest means, suggesting maintenance of the therapeutic changes over the two-month follow-up period.

Before conducting the main inferential analyses, the statistical assumptions were examined. The Shapiro-Wilk test was used to assess the normality of the distributions for distress tolerance and all marital intimacy subscales across the three groups and three measurement stages. The obtained significance values for the Shapiro-Wilk test were greater than .05 across the pretest, posttest, and follow-up stages, indicating that the assumption of normality was met. Therefore, the data were considered appropriate for mixed repeated-measures analysis of variance. The results were subsequently interpreted based on the effects of group, measurement stage, and the interaction between group and measurement stage.

Table 2. Summary of Mixed Repeated-Measures Analysis of Variance for Distress Tolerance and Marital Intimacy

Variable	Source of Variation	SS	df	MS	F	p	η²	Power
Distress tolerance	Group	402.770	2	201.385	4.595	.010	.100	.985
Distress tolerance	Time	90.000	1	90.000	210.781	.010	.834	.834
Distress tolerance	Group × Time	70.067	2	35.033	82.048	.010	.796	.808
Emotional intimacy	Group	189.295	2	94.630	6.860	.010	.246	1.000
Emotional intimacy	Time	108.900	1	108.900	545.728	.010	.856	1.000
Emotional intimacy	Group × Time	82.467	2	41.233	22.834	.010	.921	1.000
Psychological intimacy	Group	587.081	2	293.541	39.047	.010	.651	1.000
Psychological intimacy	Time	113.344	1	113.344	205.784	.010	.830	1.000
Psychological intimacy	Group × Time	44.674	2	22.337	132.674	.010	.819	1.000
Intellectual intimacy	Group	590.800	2	295.400	38.138	.010	.641	1.000
Intellectual intimacy	Time	193.600	1	193.600	312.738	.010	.882	1.000
Intellectual intimacy	Group × Time	163.400	2	81.700	131.215	.010	.855	1.000
Sexual intimacy	Group	660.904	2	330.452	31.472	.010	.601	1.000
Sexual intimacy	Time	217.778	1	217.778	255.496	.010	.857	1.000
Sexual intimacy	Group × Time	82.341	2	41.170	169.674	.010	.876	1.000
Physical intimacy	Group	389.378	2	194.689	6.284	.010	.230	1.000
Physical intimacy	Time	217.778	1	217.778	168.758	.010	.895	1.000
Physical intimacy	Group × Time	167.022	2	83.511	64.713	.010	.755	1.000
Spiritual intimacy	Group	295.393	2	147.696	10.372	.010	.331	1.000
Spiritual intimacy	Time	144.400	1	144.400	400.758	.010	.849	1.000
Spiritual intimacy	Group × Time	124.467	2	62.233	22.674	.010	.819	1.000
Aesthetic intimacy	Group	367.393	2	183.696	22.334	.010	.511	1.000
Aesthetic intimacy	Time	117.878	1	117.878	321.458	.010	.855	1.000
Aesthetic intimacy	Group × Time	97.222	2	48.611	126.215	.010	.860	1.000
Recreational-social intimacy	Group	174.948	2	87.474	5.770	.010	.214	1.000
Recreational-social intimacy	Time	134.444	1	134.444	177.568	.010	.879	1.000
Recreational-social intimacy	Group × Time	41.096	2	20.548	128.674	.010	.769	1.000

As presented in Table 2, the mixed repeated-measures analysis of variance showed that the main effect of time was statistically significant for distress tolerance and all subscales of marital intimacy at the .01 level. This indicates that participants' scores changed significantly across the pretest, posttest, and follow-up stages. The main effect of group was also significant, showing that the three groups differed in their overall scores. More importantly, the group-by-time interaction effect was statistically significant for distress tolerance and all marital intimacy subscales, indicating that the pattern of change over time differed across the reality therapy, cognitive-behavioral hypnotherapy, and control groups. Therefore, the observed

improvements cannot be attributed merely to the passage of time and reflect differential intervention effects across the groups.

Table 3. Summary of Post-Hoc Comparisons for Distress Tolerance and Marital Intimacy

Variable	Test	Comparison	Mean Difference	SE	p
Distress tolerance	Bonferroni	Pretest–Posttest	2.043	0.102	.001
Distress tolerance	Bonferroni	Pretest–Follow-up	2.006	0.134	.001
Distress tolerance	Bonferroni	Posttest–Follow-up	0.044	0.075	1.000
Distress tolerance	Tukey	Reality therapy–Cognitive-behavioral hypnotherapy	-3.511	1.396	.140
Emotional intimacy	Bonferroni	Pretest–Posttest	2.178	0.097	.001
Emotional intimacy	Bonferroni	Pretest–Follow-up	2.200	0.099	.001
Emotional intimacy	Bonferroni	Posttest–Follow-up	0.022	0.077	1.000
Emotional intimacy	Tukey	Reality therapy–Cognitive-behavioral hypnotherapy	2.880	0.784	.020
Psychological intimacy	Bonferroni	Pretest–Posttest	2.311	0.145	.001
Psychological intimacy	Bonferroni	Pretest–Follow-up	2.244	0.139	.001
Psychological intimacy	Bonferroni	Posttest–Follow-up	0.067	0.033	1.000
Psychological intimacy	Tukey	Reality therapy–Cognitive-behavioral hypnotherapy	4.350	0.524	.010
Intellectual intimacy	Bonferroni	Pretest–Posttest	2.933	0.195	.001
Intellectual intimacy	Bonferroni	Pretest–Follow-up	2.933	0.199	.001
Intellectual intimacy	Bonferroni	Posttest–Follow-up	0.003	0.077	1.000
Intellectual intimacy	Tukey	Reality therapy–Cognitive-behavioral hypnotherapy	3.660	0.585	.010
Sexual intimacy	Bonferroni	Pretest–Posttest	3.200	0.166	.001
Sexual intimacy	Bonferroni	Pretest–Follow-up	3.111	0.149	.001
Sexual intimacy	Bonferroni	Posttest–Follow-up	0.022	0.033	1.000
Sexual intimacy	Tukey	Reality therapy–Cognitive-behavioral hypnotherapy	3.867	0.684	.010
Physical intimacy	Bonferroni	Pretest–Posttest	2.511	0.173	.001
Physical intimacy	Bonferroni	Pretest–Follow-up	2.533	0.075	.001
Physical intimacy	Bonferroni	Posttest–Follow-up	0.022	0.156	1.000
Physical intimacy	Tukey	Reality therapy–Cognitive-behavioral hypnotherapy	4.156	0.795	.010
Spiritual intimacy	Bonferroni	Pretest–Posttest	4.714	0.088	.001
Spiritual intimacy	Bonferroni	Pretest–Follow-up	4.749	0.139	.001
Spiritual intimacy	Bonferroni	Posttest–Follow-up	0.034	0.073	1.000
Spiritual intimacy	Tukey	Reality therapy–Cognitive-behavioral hypnotherapy	3.622	0.605	.010
Aesthetic intimacy	Bonferroni	Pretest–Posttest	3.089	0.147	.001
Aesthetic intimacy	Bonferroni	Pretest–Follow-up	3.111	0.197	.001
Aesthetic intimacy	Bonferroni	Posttest–Follow-up	0.022	0.092	1.000
Aesthetic intimacy	Tukey	Reality therapy–Cognitive-behavioral hypnotherapy	3.000	0.587	.010
Recreational-social intimacy	Bonferroni	Pretest–Posttest	2.514	0.145	.001
Recreational-social intimacy	Bonferroni	Pretest–Follow-up	2.533	0.089	.001
Recreational-social intimacy	Bonferroni	Posttest–Follow-up	0.024	0.063	1.000
Recreational-social intimacy	Tukey	Reality therapy–Cognitive-behavioral hypnotherapy	2.733	0.673	.010

As shown in Table 3, the Bonferroni post-hoc comparisons indicated significant differences between the pretest and posttest stages and between the pretest and follow-up stages for distress tolerance and all marital intimacy subscales. However, the differences between the posttest and follow-up stages were not statistically significant, indicating that the treatment effects remained stable during the two-month follow-up period.

The Tukey post-hoc comparisons between the two experimental groups showed that reality therapy produced significantly greater improvements than cognitive-behavioral hypnotherapy in all marital intimacy subscales, including emotional, psychological, intellectual, sexual, physical, spiritual, aesthetic, and recreational-social intimacy. For distress tolerance, the descriptive means indicated greater improvement in the cognitive-behavioral hypnotherapy group than in the reality therapy group; however, based on the provided Tukey value, the direct difference between the two intervention groups was not statistically significant at the .05 level. Overall, the findings suggest that cognitive-behavioral hypnotherapy was associated with a stronger descriptive improvement in distress tolerance, whereas reality therapy showed a clearer and statistically significant advantage in improving marital intimacy.

Discussion and Conclusion

The present study aimed to compare the effectiveness of group reality therapy and group cognitive-behavioral hypnotherapy on distress tolerance and marital intimacy among couples. The findings showed that both interventions produced significant improvements in the study variables across the posttest and follow-up stages compared with the pretest stage. The results of the mixed repeated-measures analysis of variance indicated significant effects of time, group, and the interaction between time and group for distress tolerance and all subscales of marital intimacy. These findings suggest that the observed changes were not merely the result of the passage of time, but were associated with the therapeutic interventions. The Bonferroni post-hoc results further showed that the differences between pretest and posttest and between pretest and follow-up were significant, whereas the differences between posttest and follow-up were not significant. This pattern indicates that the therapeutic gains achieved after the interventions were maintained during the two-month follow-up period. In comparative terms, cognitive-behavioral hypnotherapy produced greater descriptive improvement in distress tolerance, whereas reality therapy produced significantly greater improvement in the subscales of marital intimacy. Therefore, the findings support the differential effectiveness of the two interventions, suggesting that cognitive-behavioral hypnotherapy may be more closely associated with emotional self-regulation and distress endurance, while reality therapy may be more strongly associated with relational responsibility, closeness, and marital intimacy.

The first major finding of this study was that distress tolerance improved across the intervention period, particularly among couples who received cognitive-behavioral hypnotherapy. This result is consistent with previous evidence showing that cognitive-behavioral hypnotherapy can improve distress tolerance and reduce maladaptive emotional and behavioral responses. Ahmadi Malayery et al. demonstrated that cognitive-behavioral hypnotherapy was effective in increasing distress tolerance and reducing aggression among women with premenstrual dysphoric disorder, suggesting that the combination of cognitive restructuring, relaxation, hypnotic suggestion, and emotional regulation techniques can strengthen individuals' capacity to endure negative emotional states without impulsive reaction (12). Similarly, Amin Sorkhi et al. reported that cognitive-behavioral hypnotherapy improved pain and emotion regulation, which supports the idea that this therapeutic approach can alter both cognitive appraisal and emotional arousal processes (13). The present finding extends these results to the marital context and suggests that when couples learn to identify distress-related thoughts, reduce physiological arousal, and rehearse adaptive

coping responses under hypnotic and cognitive-behavioral conditions, they may become more capable of tolerating relational stress and emotional discomfort.

The superiority of cognitive-behavioral hypnotherapy in producing greater descriptive improvement in distress tolerance can be explained through its direct focus on the cognitive, affective, and physiological components of distress. Distress tolerance is not only a behavioral capacity but also a cognitive-emotional process through which individuals evaluate whether emotional discomfort is tolerable, manageable, and temporary. Cognitive-behavioral hypnotherapy targets distorted beliefs, catastrophic interpretations, and avoidance-based responses, while hypnotic techniques may increase focused attention, relaxation, imagery-based coping, and receptivity to adaptive suggestions. In couple relationships, this may help partners remain less reactive during conflict, tolerate frustration more effectively, and respond to emotionally difficult interactions with greater self-control. Previous studies on cognitive hypnosis therapy have also shown improvements in marital and sexual outcomes, including sexual desire, marital satisfaction, body image, and marital satisfaction among women, which indicates that hypnotherapeutic and cognitive methods can influence both intrapersonal regulation and interpersonal functioning (14, 15). Therefore, the present findings are consistent with the broader literature supporting cognitive hypnotherapy as a method for modifying emotional responses, cognitive interpretations, and marital-related experiences.

The second major finding was that reality therapy was more effective than cognitive-behavioral hypnotherapy in improving marital intimacy across its emotional, psychological, intellectual, sexual, physical, spiritual, aesthetic, and recreational-social dimensions. This finding is aligned with previous studies showing the effectiveness of reality therapy and choice-theory-based interventions in improving marital intimacy, marital satisfaction, adjustment, communication, and related relational outcomes. Ebadi et al. found that reality therapy based on choice theory improved marital intimacy and satisfaction, indicating that helping couples evaluate their choices, assume responsibility, and replace controlling behaviors with need-satisfying behaviors can strengthen marital closeness (9). Besharat Qaramaleki et al. also showed that group reality-therapy-based couple therapy improved marital adjustment, emotional differentiation, and intimacy among couples with emotional divorce, supporting the view that reality therapy can be especially useful when emotional distance and weakened relational connection are central problems (5). The present study confirms these earlier findings and indicates that reality therapy may have a particularly strong effect on multidimensional marital intimacy.

The stronger effect of reality therapy on marital intimacy can be explained by the theoretical assumptions of choice theory. Reality therapy emphasizes that individuals are responsible for their behavioral choices and that relational quality depends on whether partners use connecting or disconnecting behaviors. In marital relationships, criticism, blame, coercion, avoidance, and external control tend to weaken intimacy, whereas listening, support, negotiation, respect, and responsibility strengthen emotional closeness. Through group reality therapy, couples are encouraged to evaluate what they want from the relationship, what they are doing to achieve it, whether their current behaviors are effective, and what realistic plans they can implement to improve the relationship. These therapeutic components directly address the interpersonal mechanisms underlying marital intimacy. This interpretation is supported by Moridi et al., who reported that Glasser reality therapy improved marital satisfaction, life satisfaction, and communication skills among couples (6). It is also consistent with Fallah Baranjestanki et al., who compared group reality therapy and

group cognitive-behavioral therapy and showed that reality therapy can significantly improve marital satisfaction and self-control (10).

The improvement of intimacy in the reality therapy group may also reflect the intervention's emphasis on present-oriented action and relational commitment. Unlike approaches that focus primarily on emotional insight or symptom reduction, reality therapy directs couples toward evaluating current behaviors and making concrete changes in daily interaction. Such a focus may be especially beneficial for marital intimacy because intimacy is expressed through repeated relational behaviors, including emotional sharing, physical affection, sexual responsiveness, shared recreation, mutual respect, and responsiveness to the partner's needs. Davaei Markazi et al. found that couple-therapy interventions based on reality therapy and emotion-focused therapy improved happiness and resilience among couples, suggesting that reality therapy can strengthen both individual and relational resources (7). Moreover, Soleiman Boroujerdi et al. showed that reality therapy was effective in relation to emotional divorce, communication patterns, and distress tolerance among women referred to counseling centers, indicating that this approach can influence both relational disconnection and emotional endurance (2). These findings support the interpretation that reality therapy enhances intimacy by modifying the relational patterns that maintain distance, conflict, and dissatisfaction.

The findings are also compatible with broader research on couple-based psychological interventions. Tao et al. reported in a meta-analysis that couple therapies can improve clinical outcomes among patients with post-traumatic stress disorder, which highlights the therapeutic significance of working with the couple system rather than focusing exclusively on the individual (1). In the present study, both interventions were implemented in group format and focused on couple-related outcomes, demonstrating that structured psychological interventions can improve relational and emotional functioning among couples. Similarly, Abbasi and Abbasi found that group couples therapy based on cognitive-behavioral therapy improved marital satisfaction and adjustment, while Ajri et al. reported that group cognitive-behavioral couple therapy improved marital relationship quality, marital intimacy, and marital depression among betrayed women (4, 8). These results align with the present finding that therapeutic work with couples can produce meaningful changes in marital functioning, although the mechanisms and strongest outcomes may differ by intervention model.

Another important aspect of the present findings is the stability of intervention effects at follow-up. The absence of significant differences between posttest and follow-up suggests that the improvements achieved during treatment were maintained over two months. This stability is clinically meaningful because couple interventions are not only expected to produce immediate improvement but also to create durable changes in interaction patterns, emotional regulation, and relational functioning. In reality therapy, the durability of change may be explained by the emphasis on responsible planning, self-evaluation, and behavioral choice, which can be practiced beyond therapy sessions. In cognitive-behavioral hypnotherapy, maintenance may be related to internalized coping skills, relaxation responses, cognitive restructuring, and imagery-based self-regulation. The findings of Talaeizadeh et al. on the effectiveness of hypnotherapy and schema therapy in improving emotional control among individuals affected by marital infidelity further support the idea that hypnotherapeutic approaches can produce meaningful emotional change in relationally stressful contexts (16). The present results therefore suggest that both interventions may have continuing benefits when couples apply learned skills after the active intervention phase.

The current results also have implications for understanding marital intimacy as a multidimensional construct. The significant improvement of all intimacy dimensions in the reality therapy group suggests that intimacy may be strengthened when couples change their patterns of choice, responsibility, and interaction. Emotional and psychological intimacy may improve when partners become more responsive and less blaming. Intellectual and spiritual intimacy may improve when couples develop shared meanings, values, and goals. Physical and sexual intimacy may improve when relational safety and mutual responsiveness increase. Recreational-social intimacy may improve when couples intentionally choose to spend time together and rebuild shared enjoyable experiences. The dyadic nature of intimacy is supported by Willis et al., who emphasized that sexual consent and intimate decision-making in committed relationships are relational and mutual processes rather than isolated individual acts (17). This perspective helps explain why an intervention focused on relational responsibility and mutual choice can influence multiple intimacy domains simultaneously.

The findings also contribute to the comparative literature by showing that different therapies may be more suitable for different therapeutic targets. Reality therapy appears to be particularly relevant when the main clinical goal is improvement of marital intimacy, relational responsibility, and quality of interaction. Cognitive-behavioral hypnotherapy appears especially relevant when couples need to strengthen distress tolerance, emotional control, and cognitive-emotional regulation. Talebi Rostami reported that reality therapy improved emotion regulation and distress tolerance among couples exposed to violence, which suggests that reality therapy can also affect distress-related variables (3). However, the present study indicates that when compared directly with cognitive-behavioral hypnotherapy, reality therapy may show its strongest effects in the domain of marital intimacy rather than distress tolerance. This differential pattern does not imply that one intervention is universally superior; rather, it suggests that intervention selection should be based on couples' presenting problems, therapeutic priorities, and mechanisms of change.

In general, the findings of this study support the effectiveness of both group reality therapy and group cognitive-behavioral hypnotherapy for improving psychological and relational outcomes among couples. Cognitive-behavioral hypnotherapy was associated with greater improvement in distress tolerance, which can be attributed to its focus on cognitive appraisal, relaxation, hypnotic suggestion, emotional regulation, and adaptive coping. Reality therapy produced stronger improvements in marital intimacy, which can be explained by its emphasis on responsibility, internal control, need satisfaction, effective choice, and relational behavior. These results are consistent with previous studies on reality therapy, cognitive-behavioral couple therapy, cognitive hypnotherapy, and hypnotherapy in marital and emotional domains (4, 5, 9, 11, 13, 15). Therefore, the present study adds to the literature by directly comparing two group-based interventions and demonstrating their differential effectiveness on distress tolerance and multidimensional marital intimacy.

One limitation of the present study was the use of a quasi-experimental design with purposive sampling, which may limit the generalizability of the findings to all couples. The sample was selected from couples referring to one psychology clinic in Sari, Iran, and therefore may not fully represent couples from different cultural, socioeconomic, educational, or clinical backgrounds. The sample size was also relatively small, although it was appropriate for a quasi-experimental intervention study. In addition, the study relied on self-report questionnaires, which may be influenced by social desirability, response bias, or participants'

temporary emotional states. The follow-up period was limited to two months, and longer-term maintenance of treatment effects was not examined. Another limitation was that the study compared the two interventions at the group level, while individual differences such as attachment style, severity of marital conflict, personality traits, motivation for therapy, and prior treatment history were not deeply analyzed as moderators of treatment response.

Future research is recommended to replicate this study with larger samples and in multiple clinical and community settings to increase external validity. Future studies should also use longer follow-up periods, such as six months or one year, to determine whether the effects of reality therapy and cognitive-behavioral hypnotherapy remain stable over time. It would also be useful to examine mediating variables such as emotion regulation, communication patterns, self-control, perceived responsibility, cognitive appraisal, sexual satisfaction, and attachment security to clarify how each intervention produces change. Future research may compare these approaches with other evidence-based couple therapies, such as emotion-focused therapy, schema therapy, Gottman couple therapy, and integrative behavioral couple therapy. In addition, qualitative interviews with couples could provide deeper insight into their lived experiences of therapeutic change and help identify which components of each intervention are perceived as most helpful.

Based on the findings, practitioners working with couples may consider using reality therapy when the main therapeutic goal is to improve marital intimacy, relational responsibility, communication, commitment, and mutual closeness. Cognitive-behavioral hypnotherapy may be particularly useful when couples experience high emotional reactivity, low distress tolerance, difficulty regulating negative affect, or intense physiological arousal during conflict. Counselors and family therapists can also integrate selected components of both approaches when couples present with both intimacy deficits and emotional dysregulation. Group-based delivery may be beneficial because it provides opportunities for normalization, interpersonal learning, modeling, and shared practice among couples. Clinical implementation should include careful assessment of couples' needs, readiness for group therapy, conflict severity, and psychological safety before assigning them to an intervention format.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

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

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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