The effectiveness of group therapy based on commitment and acdmission on the sexual satisfaction of people with empty nest syndrome.

Mohammad Tahan[1]*, Zahra Askari[2], Elahe Ahangri[3]

[1]Young Researchers and Elite Club, Birjand Branch, Islamic Azad University, Birjand, Iran
[2]Department of Clinical Psychology, Islamic Azad University, Torbat Jam Branch, Iran
[3]Department of Clinical Psychology, Payam Noor University of Tehran, Iran

Abstract

Background and aim: The purpose of this study was to determine the effectiveness of admission therapy and commitment to group method on increasing sexual satisfaction in people with Empty nest syndrome. This semi-experimental research is a post-test pre-test with control group.

Materials and methods: The statistical population was comprised of all men and women in the city of Tehran, whose children left them and separated from them. By using of available sampling method 30 people were selected. For data collection, in the post-test phase the Larsson Sexual Satisfaction Questionnaire was used. The experimental group received acceptance and commitment group therapy in 8 sessions of 2 h and the control group received no therapy. In the post-test phase, the above questionnaires were repeatedly administered to both groups. For data analysis, descriptive and inferential statistics (covariance analysis test) were used.

Findings: The findings showed that the mean of sexual satisfaction scores in the post-test and the experimental group was significantly higher than the mean of post-test scores in the control group.

Discussion and conclusion: Based on the findings of this research, it can be concluded that commitment and admission therapy to group method is effective in increasing sexual satisfaction in people with empty nest syndrome.

Keywords: Admission and commitment, Sexual satisfaction, Empty nest syndrome.

Accepted on August 30, 2017

Introduction

The concept of family and the value of this social institution for each state and society are considered the basis of the work and each society commensurate with its values first goes to the family to develop its future citizens from within it. This issue becomes more important when the society due to structural changes and infrastructure needs to new citizens with modern thinking. That is why the family is one of the first institutions to be changed in society and it will not change unless through the perception and recognition of its functions and its wickedness, the entry into such an organized system is merely through Birth, adoption or marriage [1]. As Kaye has stated, families create new members and although they eventually give these new members autonomy, they no longer expect to live with them under a roof [2]. The family in terms of the structure is complex emotional system that may include at least three, or because of the longer lives of humans, four generations. The family, regardless of tradition or novelty, adaptation or incompatibility, and its efficient or disturbing construction, must inevitably make itself as efficient or capable group as possible in order to meet its needs and collective or collective and general goals without constantly persuading its members to achieve their goals and personal needs [3].

The characteristics of all families are love, loyalty, and continuity of membership. These are the feature that distinguishes it from other social systems [4]. When these features are challenged, like when occurs a family crisis, usually again the family is shown resistance against the change and to restore his familiar interactive patterns will have to take corrective actions. Each family, regardless of its form (for example, the nuclear family, the single family, and the single parent family) or the final success that he gets, must strive to promote the positive and desirable relationships among its members, pay attention to their personal needs, and ready to cope with changes due to sedition (for example, when their children leave the house), as well as unexpected crises (divorce, death, sudden acute illness) [1].

One of these changes is the abandonment of the house by the children. The transition to an empty nest or a period is when children leave their father's home permanently, is a normative event of a stage of growth that humans encounter in the middle of life.

Empty nest syndrome means feeling depressed, anxious and lonely [5]. Lever states that involvement in an empty nest syndrome means losing parental control over the situation rather than losing children, so the empty nest syndrome not only means losing (or leaving the children away from home) [6]. But also implies the painful consequences of this problem [7].

Leaving the house by children can be frightening for couples who have filled their vacancies relationships with their children. As soon as the children leave the house, the husband and wife try to give meaning to their lives or relationships.

In this period, there are some discomforts and even negative stress that they call "empty nest syndrome" or "Deserted nest syndrome". Nest syndrome is a kind of depression that after the last child left the house; it is created in the woman and the man.

In this period, if compensatory activities are not done, especially by the mother, parents may be depressed in some cases. This is especially true in cases where main role of woman in life is raising children and motherhood or that husband and wife have endured their unfortunate common life because of their children [8].

On the other hand, Shahnaz et al. [9] showed that there is a relationship between empty nest syndrome and sexual satisfaction and function. The findings of the redearchers have shown that sexual activity is in the first place of marriage life and sexual satisfaction can provide a convenient and convenient marriage [10]. Sexual satisfaction is a situation in which couples feel happiness, satisfaction and love with each other [11]. Sexual relationships form part of the important perceptions of couples from one another, which is the continuation of the marriage [12].

Sexual satisfaction not only brings warmth and passion to couples, but also preserves them against many disorders and diseases, and there is a significant relationship between sexual satisfaction and satisfaction from the marriage life [13].

Bremen et al. in the study showed that there is a relationship between sexual satisfaction and depression and anxiety [14]. Dissatisfaction with the sexual relationship can lead to deep problems in couples' relations and hatred of the wife, annoyance, jealousy, competition, sense of revenge, feelings of humiliation, feelings of self-confidence and so on. These issues are reinforced by tensions and differences and changes (such as leaving a child) or are manifested in the form of them and gradually deepen the gap between spouses [15].

One of the approaches that can help reduce marital dissatisfaction is therapy based on admission and commitment. Azimifar, Fatehizadeh, Bahrami, Ahmadi and Abedi showed that therapy based on admission and commitment is effective in increasing marital happiness among dis-satisfied couples.

Therapy based on admission and commitment has entered psychology since 1990 and is among third wave therapies of behavioral therapy and a branch of new psychological therapies, which is also called admission treatments. Therapy based on Admission and commitment is a behavioral therapy that uses mindfulness, admission and cognitive defusion to enhance psychological flexibility [16].

Psychological flexibility means increasing the ability of users to connect with their experience in the present and based on what is possible at that moment for them, and act in the manner that be consistent with their chosen values [17]. This therapy includes a combination of metaphor, attention-aware skills, a wide range of empirical exercises and behavioral interventions directed according to authorities values used by therapist. The purpose of this therapeutic approach is to help authorities to achieve a more valuable and satisfying life through increased psychological flexibility, which is to improving the ability to communicate with experiences in the present and practical choice through options Different, which is more appropriate,rather than practice merely to choose from thoughts feelings, memories or disturbed desires [18]. The effectiveness of this therapeutic approach in treatment of psychological problems is more effective than other common therapies [19], and has been shown to beeffective in a wide range of clinical settings, such as depression, Anxiety, post-traumatic stress disorder [20].

Therefore, if couples relationships are companied with satisfaction have a good effect on mental health and coping with their problems, and if couples can increase the level of satisfaction in their marriage life, in addition to maintaining a couple relationships, they can also protect their family's foundation from the damage. Therefore, according to the stated issues and lack of research in relation to this method of therapy on the sexual satisfaction of people with empty nest syndrome, the purpose of the present research is to answer this question whether therapy based on commitment and admission has an effect on sexual satisfaction of people with empty nest syndrome?

Materials and Methods

The research method was semi-experimental with pre-test and post-test design with control group. In this design, two groups of subjects are randomly selected, the test group is measured before the independent variable is run with a pre-test, after that this group is exposed to an independent variable, it is measured with the post-test but The control group for one time after performimg the independent variable of the test group, they are subjected to post-test simultaneously. Of course not to be missed that the subjects in the pre-therapy stage (baseline), the first and last session of therapy (eighth session) completed the sexual satisfaction questionnaire.

After completing the sessions, the post-test was performed from both groups and the follow-up phase was performed after 1 month. Eventually, the entire program was made up of a pre-session, 8 sessions of therapy and a follow-up session.

The therapy nethod used in this research, is an extended version of the admission and commitment therapy plan that scientifically and practically is approved by the Board of Scientific Advisers [21]. The therapy plan of the sessions is briefly presented in Table 1.

Statistical population and sample group

The statistical population of the study was kidneys, middle-aged people whose children left their marriage, or left school or work, and were generally short of suffering, and in 2016 they were referred to the Dr. Seyed Modarres Center and received a diagnosis of depression, gave. In this research, available sampling method and random sampling method were used. A total of 30 individuals were selected from the statistical population and randomly divided into two groups of control and control group (15), the experimental group received group acceptance and commitment, and the control group was compared in the waiting list.

Statistical population and sample group

Information gathering tool.

Sexual satisfaction questionnaire

Sexual Satisfaction Questionnaire by Larson, this questionnaire has 25 questions, which has 13 negative and 12 positive questions. In response to each question, five choices based on the Likert spectrum (never, rarely, sometimes, most often and always) are included. The scores are between 25 and 125, with scores below 50 meaning lack of sexual satisfaction, 51-75 low satisfaction, 76-100 average satisfaction, and more than 100 refers to high sexual satisfaction. In the research of Sattarzadeh, Bahrami, Ranjbar, Kochaksara and Ghowha [22], the reliability of this questionnaire was reported using the Cronbach's alpha coefficient for the fertility group 93.03 and the infertile group 89.0.

In the study of Bahrami, Yaghoobzadeh, Sharifinya, Soleimani and Haghdoost with the help of Cronbach's alpha, the reliability of positive questions of sexual satisfaction was 0.84 and the reliability of the negative questions of sexual satisfaction was 0.77. The cluster internal correlation index was 0.80. This indicates the suitability of the whole tool.

Analysis of data

Data analysis was performed using SPSS statistical software 18 version and using descriptive, analytical and quanarian methods.

Findings

The demographic data of the subjects showed that the mean of age in the experimental group was 90.8 ± 72.99 and in the control group was 30.7 ± 23.49 years. The mean of education in the experimental group was 92 ± 52.7 and the control group was 30.17 ± 8.8. the level of superdiploma education and being housewife in both grops was the most frequent, also the results showed that In terms of economic situation in the experimental group were 20% weak, 7.66% moderate and 3.13% good and in the control group were 26.7% poor, 62.1% moderate and 11.2% good respectively, which suggests the similarity of the two groups of experiment and control based on gender and other variables studied (Table 2).

The results of this study are as follows:

To perform parametric tests, first, the default of the distribution of data in the research variable was calculated using Glomogorov-Smirnov test. The significance levels obtained in the variable are greater than 0.05. Therefore, the default is set and the implementation of parametric tests is allowed (Table 3).

Before implementing the covariance analysis, its defaults are reviewed.

First, the equality precondition of variances was studied using Levin's test. As the results of the Levine test show, in all variables, the equality precondition of variances is set (P>0.05) (Table 4).

In the following, the same precondition of the slope of the regression line was examined. For this purpose, from the

Table 1. *Summary of the content of the acceptance and commitment plan.*

Sessions	Contents
First session	Group familiarity with each other and establishment of therapeutic relationship; Familiarizing people with subjects of research; Study of MS disease in each group including the duration of the disease and the actions taken; Overall measurement and measurement of control techniques and create creative helplessness and response To questionnaires.
Second session	Examines the inside and outside world in the therapy of ACT; the desire to leave the ineffective program of change and to understand this issue that control is problem not a solution and introducing a replacement for control, that is, willingness.
Third session	Identification of the values of individuals; Reaffirmation of values; specifying goals; Specifying actions and specifying obstacles.
Fourth session	Review the values of each individual and deepen the previous concepts.
Fifth session	Understanding mixing and faulting and doing exercises for faulting.
Sixth session	Understanding mixing is self-conceptualized and learns how to fault it.
Seventh session	Mindfulness and emphasis for being in time.
Eighth session	Evaluating the life story and acting commitment.

Table 2. *Pre-test and post-test table - Mean and standard deviation of pre-test and post-test of sexual satisfaction.*

Post-test		Pre-test			
The standard deviation	Mean	The standard deviation	Mean		
0/86	4/8	1/36	3/87	Test	Sexual satisfaction
1/5	3/4	1/68	3/43	Witness	

Table 3. *Normal table-Kolmogorov-Smirnov test.*

Significance level	Degree of freedom	Amount of statistic	
0/18	30	0/071	**Pre-test for sexual satisfaction**
0/26	30	0/024	**Post-test Sexual satisfaction**

Table 4. *Table of equations of variances - Levin statistic for the test of equality of variances.*

Significant level	Degree of freedom 2	Degree of freedom 1	Amount F	
0/39	28	1	0/75	**Sexual satisfaction**

Table 5. *The same test table is the slope of regression line for test and control groups.*

The significance level	Amount F	Mean squares	Degree of freedom	Sum of squares	Source of changes	
0/84	0/39	0/43	1	0/43	pre-test group	**Sexual satisfaction**

Table 6. *Covariance coefficients variable indicator table. The effect of group membership on sex in post testing stage between the witness and control group.*

Effect Level (ETA)	The signific ance level	amount f	Mean squares	Df	Sum of squares	Variable index
0.66	0/01	53/37	27/89	1	27/89	**Pre-test**
0/36	0/01	15/34	8/01	1	8/01	**Group membership**
			0/52	27	14/1	**Error**
				40	**561**	**Total**

test of the interactive effects of the group variable with pre test was used (the calculated F value for this effect is not meaningful in all cases, therefore, the slope of the regression line is the same for the experimental and control groups (the interaction between the experimental conditions and the equilibrium variable is not meaningful) and the use of covariance analysis is allowed (Table 5).

The results of covariance analysis show that by eliminating the effect of pre-test scores of sexual satisfaction, the main effect of ACT therapy on sexual satisfaction is significant and the observed difference between the means of the participants sextual satisfaction scores (test-control) by group membership in The post-test stage is significant with 99% confidence ($P<0.01$). The effect of this intervention was (0.36) (Table 6).

The zero hypothesis is rejected and the hypothesis of the test is confirmed, i.e., there is significant difference between the sexual satisfaction of people with empty nest syndrome treated with ACT and those who have not been treated, and after ACT therapy in the experimental group, the mean of Sexual satisfaction score has increased with regard to the effect of pre-test and on the witness group.

Discussion and Conclusion

The purpose of this research was to investigate the efficacy of admission and commitment therapy to group method on sexual satisfaction in patients with empty nest syndrome. According to the findings of this research, it can be concluded that the use of admission and commitment therapy to group method in the sexual satisfaction of people with empty nest syndrome is effective. There is a significant difference between the sexual satisfaction of people with empty nest syndrome that treated with ACT and those who have not been treated. The results of this research are in line with the results of Shahnaz et al. [9]. Also, Peterson et al. showed that the therapy based on admission and commitment increases the compatibility of distressed couples, which is consistent with the results of this research [23]. Burpee and Langer also confirmed the effectiveness of this therapeutic approach on marriage satisfaction [24].

Therapy based on admission and commitment which is briefly refered to as (ACT) is a third-wave therapeutic behavior. The philosophical foundation of this approach is functionalism. A behavioral analysis of cognition that language relational theory, regular behavior (based on rule) and therapy based on admission and commitment are based on it. This obviously embraces this approach (changing the function of thoughts and emotions rather than transformation, content or abundance of them). ACT has a roots in a philosophical theory called functional grounding and is based on a research program about language and cognition that is called the mental relations framework theory. ACT has six central processes that lead to psychological flexibility. These six processes are: acceptance, fault, self as a background, relationship with the present, values and an act of commitment [25].

People with empty nest syndrome focus on their thoughts and in order to change the shape or abundance of false thoughts they enter into the range of escape and avoidance behaviours.

One of the ACT key processes associated with these cases is cognitive fault, which is to set up verbal contexts, so that belief in one's thoughts decreases and the tendency to respond to them is also reduced, while a decrease in frequency or their shape change is not necessary. ACT interventions have shown a significant increase in the tendency to engage in difficult activities while experiencing difficult emotions [26].

ACT's central processes teach people how to avoid inhibition, how to not interfere with intrusive thoughts, and cause an individual to endure the unpleasant emotions [27]. Many clinical symptoms and manifestations of depression

disorder such as avoidance, inhibition of thought, impaired quality of life, mood problems are appropriate for therapy based on admission and commitment [28].

In fact, admission and commitment therapy leads to an agreement among couples and the training of ways to adapt to the intolerable aspects of marriage life rather than trying to manage conflicts and conflicting factors. On the other hand, this approach emphasizes the discovery of the values of couples and how to create a meaningful life for themselves and their spouses through the creation of personal values, and these couples will consider all their life experiences in order to find ways to live efficiently. And tolerate the distraction of children admission and commitment therapy with emotional avoidance therapy, improving reactions, identifying values, and creating commitment to behavioral changes can help couples improve their relationships and can utilize skills that can be learned by engaging in couples' treatment sessions modify their unpleasantness feelings and experience them instead of controlling and challenging undesirable thoughts and feelings and Not only do they experience their feelings and thoughts, but also allow their spouse to have such an experience. And by appling fault skills, they communicate with their intrinsic experiences and unpleasant emotions and thoughts, and to avoid them don't being involved in negative communication patterns and behaviors, thus preventing the creation of double negative emotions "admission" is a designed and courageous mode from the authorities and helps him to fully and unprotected experience aspects of his psychological experience (bad, good and ugly) as it is. Our goal is to create an efficient person who is sincerely without anxiety to be in contact with his own experiencing World. Admission "means the experience of senses, emotions and thoughts, without any effort to change them."Admission" especially when it comes to necessity that experience can not be changed and should not be changed. This contradictory state allows the authorities to be what it is and where it is present and to reduce its tendency to change their thoughts and feelings [29]. When authorities concerns about the future, people who have an empty nest syndrome related to emotional and cognitive content and distress about the unwanted physical state decreses, what remains is a human being with a dysfunctional life. The main purpose of the admission and commitment therapy ", change the direction of attention, the effort of clients from the vain goals (reducing unpleasant feelings and thoughts) toward actions based on their desires from a desirable life desires from a desirable life. The whole efforts by the psychotherapist for grow and cultivate of life based on value, admission, and commitment" is to help clients find their way of life and just do it. Therefore, therapeutic efforts will focus on behaviors that are in line with the values selected by the authorities. In fact, admission and commitment interventions increase sincere responses and the exchange of positive feelings among couples and increase sexual satisfaction and reduce the consequences of child abandonment. This is in line with the results of this research. One of the most important limitations of this research is the inability to use multi-therapist to accelerate and optimize information and data. And the next limitation was the lack of Persian resources and the lack of use of this therapy on sexual satisfaction, especially in people with empty nest syndrome in the country. Therefore, according to the findings of the research, it is suggested that in order to its generalizability, research be carried out on other groups in terms of cultural, social and sexual categories. And the main suggestion of this research is that in therapy sessions, regardless of the theoretical or consultative and therapeutic approach adopted, in order to optimize the therapy of this disorder, a plan should be considered to increase the "admission" of clients.

References

1. Irene G, Herbert G. Family therapy. In Reza H, Broooti HS, Nakhshbandi S, Arjmand E (edtrs), Roshan Publishing house, Tehran. 2016.
2. Kaye K. Toward a developmental psychology of the family. The Handbook of Family Psychology and Therapy, Dorsey Press, Homewood, IL. 1985.
3. Mohammad K, Faramarz S. The effectiveness of semantic meaning therapy on depression and increasing hope in the elderly with nursing syndrome. Clin Psychol Stud. 2014;4(15):79-104.
4. Terkelson KG. Toward a theory of the family life cycle. Gardner, E.A., New York. 1980.
5. Fatemeh M, Mohammad K, Maryam H. Compare nursing syndrome in parents before and after the home by the children. Knowledge and Research in Applied Psychology. 2014;15(4):29-37.
6. Lever HZ. Women as widows: Support systems. Elsevier, New York. 1977.
7. Moen P, Wethington E. Midlife development in a life course context. Life in the middle: Psychological and Social Development in Middle Age. Academic Press, San Diego. 1999;3-24.
8. James SB, Virginia S. Psychiatric summary, behavioral sciences: Clinical Epidemiology. Arjmand Publications, Tehran. 2016.
9. Shahnaz N, Pourandokht A, Parvin A, et al. Investigating the relationship between vacancy nest syndrome and sexual satisfaction and sexual function among middle-aged women. Research project of Ahvaz Jundishapur University of Medical Sciences. 2016.
10. Alahveriani K, Rajaie H, Shakeri Z, et al. Studying the relationship between sexual disorder and marriage satisfaction in those suffering from depression. Procedia Soc Behav Sci. 2010;5(0):1672-5.
11. Ziaee T, Jannati Y, Mobasheri E, et al. The relationship between marital and sexual satisfaction among married women employees at Golestan University of medical sciences, Iran. Iran J Psychiatry Behav. 2014;8(2):44-51.

12. Zahra A, Behnaz N, Azra M, et al. The effect of sexual counseling on marital satisfaction in pregnant women: A clinical trial study. J Nurs Midwifery. 2016;24(4):256-92.
13. Azam R, Khoi M, Sadeghi C, et al. Relationship of sexual satisfaction and satisfaction with marital life. Iran J Nurs. 2011;70:82-90.
14. Berman JB, Berman LA, Kanaly KA. Female sexual dysfunction: New perspectives on anatomy, physiology, evaluation and treatment. EAU Update series. 2003;1:166-77.
15. Christopher FS, Sprecher S. Sexuality in marriage, dating, and other relationships. J Marriage Fam. 2000;62:999-1017.
16. Forman EM, Herbert JD, Moitra E, et al. A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. Behav Modif. 2007;31(6):772-99.
17. Hayes SC. Practical guide to acceptance and commitment therapy. Springer Science and Business Media Inc., New York. 2010.
18. Frank A, Atta S. Acceptance and commitment therapy to reduce symptoms of stress, anxiety and depression in women with experience of exaggerated relationships (emotional, sexual). J Nurs. 2016;4(6):8-13.
19. White RG, Gumley AI, McTaggart J, et al. Acceptance and commitment therapy for depression following psychosis: An examination of clinically significant change. J Contextual Behav Sci. 2015;4(3):203-9.
20. Russ H. An interview with Dr. Russ Harris concerning acceptance and commitment therapy. Psychology Services and Life Consultation Website, Tehran. 2014.
21. Hayes SC, Levin ME, Plumb-Vilardaga J, et al. Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. Behav Ther. 2013;44(2):180-98.
22. Niloufar S, Nasim B, Kuchaksarai R, et al. Comparison of sexual satisfaction and depression among fertile and infertile couples referring to Alzahra Educational Center Tabriz. Journal of Research in Lorestan University of Science and Technology. 2006;9(2).
23. Peterson BD, Eifert GH, Feingold T, et al. Using acceptance and commitment therapy to treat distressed couples: A case study with two couples. Cogn Behav Pract. 2009;16:430-42.
24. Burpee LC, Langer EJ. Mindfulness and marital satisfaction. J Adult Dev. 2005;12(1):243-67.
25. Hayes SC, Luoma JB, Bond FW, et al. Acceptance and commitment therapy: Model, processes and outcomes. Behav Res Ther. 2006;44:1-25.
26. Masuda A, Hayes SC, Sackett CF, et al. Cognitive diffusion and self-relevant negative thoughts: Examining the impact of a 90 year old technique. Behav Res Ther. 2004;42(4):477-85.
27. Twohig MP. The application of acceptance and commitment therapy to obsessive-compulsive disorder. Cogn Behav Pract. 2009;16(1):18-28.
28. Levitt JT, Brown TA, Orsillo SM, et al. The effects of acceptance versus suppression of emotion on subjective and psychophysiological response to carbon dioxide challenge in patients with panic disorder. Behav Ther. 2004;35(4):747-66.
29. Eifert GH, Forsyth JP. Acceptance and commitment therapy for anxiety disorders. New Harbinger, Oakland C. 2005.

***Correspondence to:**

Mohammad Tahan
Young Researchers and Elite Club
Birjand Branch
Islamic Azad University
Birjand
Iran
Tel: 989363049935
E-mail: t.mohammad2@gmail.com