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Research Paper

Effectiveness of the Combined Emotion-Focused and Solution- focused Therapy on the Anger and Marital Adjustment of the Women with Marital Conflicts

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Emotion-oriented therapy, solution-focused therapy, marital adjustment, marital conflict

ABSTRACT

Objective: The aim of this study was to investigate the effectiveness of a combination of emotion-oriented and solution-focused therapy on anger and marital adjustment in women with marital conflict.

Methods: This study was applied in terms of purpose and semi-experimental data collection method with pre-test and post-test design with a control group. The statistical population included women with marital conflicts in Tehran in 2019. Thirty women with marital conflicts were selected by purposive sampling method and randomly assigned to experimental and control groups. The experimental group underwent 10 sessions of combined emotional and pathological therapy for two and a half months, while the control group did not receive the present intervention. The questionnaires used in this study included the Marital Conflict Questionnaire (MCQ), Anger Control Questionnaire (ACQ), and Marital Adjustment Questionnaire (MAQ). The data were analyzed using covariance analysis.

Results: The results showed that the combination of emotion-oriented and solution-focused therapy on anger management (P 000 0001; Eta = 0.41; F = 12.71) and marital adjustment (P 000 0001; Eta = 0.45; 15.25 F) Women are affected.

Conclusion: Considering the significant effect of combination therapy based on emotion and solution, it is recommended to use this combination therapy in order to improve marital adjustment and anger of women with marital conflicts.

1. Introduction

Marital conflicts are formed as a result of dissatisfaction with marriage and cohabitation. Marital conflict intensifies when feelings of anger, hostility, resentment, hatred, jealousy, and verbal and physical abuse dominate the couple's relationship (Javadan et al., 2023). Marital conflict is one of the topics of interest for couples therapists. This problem can take many forms and can occur in the form of depression in one or both spouses, addiction, abnormal behavior between children, spousal abuse, and verbal and physical conflict between both spouses and eventually lead to divorce (Cribbett et al., 2020). When the intimate relationship between husband and wife is damaged, and marital understanding is reduced, destructive and negative effects on the mental health of the family, as well as the mental health of the children, occur. Therefore, increasing understanding and marital compatibility and facilitating the family

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environment are considered the primary mental health measures and are important in education (Li & Liu, 2020). Marital conflicts gradually lead to aggression and anger toward the spouse (Moradi & Sadeghi, 2019); these people lose control of their anger over time and become aggressive more quickly (McDermott et al., 2017).

Anger refers to emotion, hostility, attitude, aggression, and behavior, and this emotion can be the basis of aggression. Aggression consists of three components: aggressive feelings, aggressive thoughts, and aggressive behavior. *Aggressive feeling* is an emotional state that underlies aggression and hostility, called anger. *Aggressive thoughts* are an inclusive attitude that leads a person to aggressive behaviors, which is called hostility. *Aggressive behavior* is the observable behavior done with the intention of harming (Donald et al., 2019). Although emotional anger is natural and can sometimes be helpful, it also carries risks. When anger is out of control and destructive, it can lead to problems in interpersonal relationships and overall quality of life (Thomas et al., 2019; Allahyari, 2021). Anger affects many aspects of life. Expressing anger can lead to marital, family, communication, and workplace conflicts and create a negative attitude towards the person (Moradi et al., 2019). Marital disputes and conflicts, with decreased marital intimacy (Saemi et al., 2019), also reduce marital compatibility (Fotouhi et al., 2018). *Marital adjustment* is a situation in which a couple often feels happy and satisfied and enjoys being together. This compatibility is created through mutual interest, care, acceptance, understanding, and satisfaction of need (Cirhinlioglu et al., 2017). *Marital compatibility* is a multidimensional term that describes the multiple levels of marriage and is a process that occurs during the couple's life because it requires adapting tastes, recognizing personal traits, creating rules of behavior, and forming communication patterns. Therefore, marital adjustment is an evolutionary process between husband and wife (Omrani et al., 2019). The main cause of marital incompatibility is not the amount of anger expressed or the number of conflicts but the humiliation and defensive distance that cause marital disturbances. Marital adjustment contributes to the overall adjustment of the individual, i.e., spouses who have high marital adjustment have more self-esteem and show higher adjustment in social relationships (Goldfarb et al., 2019). On the other hand, marital adjustment also affects the quality of life of couples and causes couples to show more positive interaction (Yousefi et al., 2011).

Various therapeutic and educational methods have been used for couples, especially conflicting women. One of the most widely used therapies is emotion-oriented therapy. Results of Sahebi Bazaz, Sudani, and Mehrabizadeh (2019); Raisi et al. (2018); Zanganeh et al. (2017); Webb and Johnson (2017); Moore et al. (2016) indicate the effectiveness of this treatment. The purpose of the emotional couple approach is to access and reprocess emotional reactions. Emotional in couples' interactions. These reactions lead to the development of safer attachment styles and a different pattern of couples 'interaction, couples' empathy for each other, and the development of new patterns of interaction (Moore et al., 2016) (. The process of change in emotion-oriented couple therapy is organized into nine steps. The first four steps require evaluation and de-intensification of the problem-carrying interactive cycle. The three intermediate steps focus on creating specific events that help change and relocate interactive situations and the occurrence of bonding interactions, and the last step of treatment refers to the integration of change with the couple's daily life. If the parties successfully discuss these steps, they gain the ability to resolve marital disputes (Davarnia et al., 2015).

Another widely used treatment method for conflicting couples is solution-based therapy, which is the result of Arianfar and Rasouli (2019), Mohammadyari and Hosseinian (2018), Aghaei et al. (2018), Olyazadeh and Reisi (2017); Abbasi et al. (2017)show the effectiveness of this treatment for women with job conflict. Solution-focused therapy aims to break repetitive and ineffective behavioral sets by deliberately creating situations in which the person has a more positive view of difficult situations and actively participates in doing different things. "What's the problem?" And "What is not?" From this point of view, solution-based is comparative (Dejong, Berg, 2012). In this way, it is believed that people should be helped to open their fixed vision, get creative, and create new approaches that can be used in different situations. This approach focuses on finding the capabilities and capabilities of clients. Solution-focused therapy has a non-pathological cognitive perspective on clients and helps clients find solutions to their current problems (Brzezowski, 2012). Therefore, solution-oriented therapy is based on solution-building, not problem-solving, and is guided by discovering the current forces of reference and hope for the future, not by discussing existing problems and their causes in the past. Basically, short-term solution-based treatment is based on the premise that it will change clients' perceptions of their problems and possible solutions (Wand, 2010). They are now considering the psychological,

communication, and emotional disorders in couples with marital conflicts, low marital adjustment, and high marital anger (Fotouhi et al., 2017; Saemi et al., 2019; Omrani et al., 2018) and the importance of using appropriate treatment methods and interventions such as emotion-oriented and solution-focused treatment and confirming its effectiveness in various types of research (Sahebi-Bazaz et al., 2019; Arinefar & Rasouli, 2019; Raisi et al., 2018; Aghaei et al., 2018; Olyazadeh & Reisi, 2017; Abbasi et al., 2017; Zanganeh Motlagh et al., 2017; Webb & Johnson, 2017). Applying a combination of the two therapies can have a synergistic effect on increasing marital adjustment and reducing marital anger. Now, considering the issues raised and the lack of research to investigate the effectiveness of combined emotional and solution-oriented therapy on anger and marital adjustment, the main issue of the present study is to evaluate the effectiveness of combined emotional and solution-focused therapy on anger and marital adjustment. Women had marital conflicts.

2. Materials and Methods

In terms of data collection and practical purpose, this study was semi-experimental, with a pre-test design, a post-test with a control group, and a three-month follow-up period. The statistical population of the study included women with marital conflicts who were referred to counseling centers in Tehran in 2019. In this study, 30 women with marital conflicts were selected by purposeful sampling. The purposeful sampling method is based on inclusion criteria. This method was chosen because of the lack of full access to the entire statistical population. In this study, first, conflicting women referred to counseling centers in Tehran were identified (Due to the high volume of counseling centers in Tehran, 5 centers were selected). Then, the forms of participation in the research were distributed voluntarily among the conflicting women. After identifying the female volunteers, they were presented with a marital conflict questionnaire. By administering and scoring the Marital Conflict Questionnaire, 30 women who had obtained a score higher than 126 in the Marital Conflict Questionnaire were selected and randomly assigned to the experimental and control groups (15 women in the experimental group, a combination of emotion-oriented and solution-oriented therapy, and 15 women in the control group). Inclusion criteria included: female gender, having a history of married life of more than three years, having marital conflicts, willingness to continue living together with a spouse, having at least a diploma, having physical health, and willingness to participate in research. It should be noted that the exit criteria also included absence in two training sessions, non-performance of required assignments, and the occurrence of unpredictable accidents. Finally, the experimental group members underwent 10 sessions of combined treatment of emotion-oriented and solution-oriented for two and a half months. However, the control group did not receive these interventions and continued its usual treatment process in counseling centers. The trainers were two people, one of whom was a PhD student in counseling and a specialist in the field of solution-focused treatment, and the other had a master's degree in counseling and a specialist in the field of emotion therapy. In order to observe research ethics, the researcher's first step was to develop forms related to the informed consent of the participants in the research project, which was presented to the participants (women). In these forms, items such as confidentiality of the names and details of the participants in the research at all stages, being aware of the results of all individual assessments by the researcher, the existence of participants' right to cancel, and alternative methods were considered. In addition, women were satisfied with participating in the intervention program and were informed of all stages of the intervention. The control group was also assured that they would receive these interventions after completing the research process. Both groups were also assured that their information would remain confidential and that no names would be required. The following questionnaires were used to collect data:

Marital Conflict Questionnaire (MCQ): Questionnaire 54 questions on marital conflicts were developed by Sanai et al. In 2000, to measure the dimensions of marital conflicts. This questionnaire measures eight dimensions of marital conflicts, which include decreased cooperation, decreased sex, increased emotional reactions, increased child support, increased personal relationships with relatives, decreased family relationships with relatives, spouses, and friends, separation of financial affairs, and reduced effective communication. An example of a questionnaire is "When I argue with my spouse, my relationship with his or her parents' family is cut." Its scoring method is based on a five-point Likert scale (from a score of 1 for "strongly disagree" to 5 for "strongly agree"). The maximum total score of the questionnaire is 270, and the minimum is 54. In this tool, a higher score means more conflict and a lower score means a better relationship and less conflict. Questions 3, 11, 14, 26, 30, 33, 45, 47, 54 are scored in reverse. In the study of

Sanaei et al. (2008; quoted by Bakhshipour et al., 2012), Cronbach's alpha for the whole questionnaire on a group of 270 people was equal to 0.96 and For its 8 subscales it is as follows: reduction of cooperation, 0.81; Decrease in sex, 0.61; Relief of emotional reactions, 0.70; Increased child support, 0.33; Increasing personal relationship with relatives, 0.86; Decreased family relationship with spouse relatives and friends, 0.89; Separation of finances from each other, 0.71; And effective communication reduction, 0.69. Cronbach's alpha for the whole scale was 0.71, and its seven subscales ranged from 0.60 (decreased sex ratio) to 0.81 (decreased relationship with spouse's family). Its predictive validity for predicting confirmed psychiatric patients, including migraine headache prediction, was equivalent to (p = 0.01 and 0.28) (Ebrahimi et al., 2008).

Marital Adjustment Questionnaire (MAQ): The Marital Adjustment Questionnaire was developed by Spanier in 1976 to measure the degree of adjustment of two people (couple) and is a self-assessment questionnaire. This questionnaire has 32 questions. Sample question of this questionnaire: "How often have you thought about or discussed divorce, separation, or ending your relationship?" Is. The scores of this questionnaire vary from 0-151, which means that scores equal to or lower than 100 mean the compatibility of individuals, and scores less than 100 mean that there is a problem in marital relations and incompatibility and family understanding. Spinner reports the internal consistency coefficient of this widely used scale from 0.92 to 0.96 and a high standard of validity for it. This scale measures four dimensions of a relationship: marital satisfaction, marital solidarity, marital agreement, and expression of emotion. Spinner (1976) obtained the reliability of sub-scales for marital satisfaction at 0.94, marital agreement at 0.9, marital solidarity at 0.86, and expression of affection in marital relationships at 0.73, respectively. Also, the overall validity of this questionnaire was reported based on a correlation of 0.86. In the study of Hassanshahi et al. (2010; quoted by Modarressi et al., 2014), the validity of this scale was 0.92, and its reliability was 0.75. The reliability of this questionnaire in the present study was calculated using Cronbach's alpha coefficient of 0.74.

Anger Control Questionnaire (ACQ): The Anger Questionnaire was developed by Spielberger et al. (1985). The questionnaire consists of 57 items, including 6 scales, 5 subscales, and an anger expression index that provides an overall measure of anger expression and control. An example of a questionnaire is "When I do a good job, but my work is underestimated, I get angry." It scores based on a four-point Likert scale (from a score of 1 for "never" to 4 for "always"). The maximum total score of the questionnaire is 57, and the minimum is 228. In this tool, a higher score means more anger and a lower score means less anger. The reliability of the questionnaire for standardization was determined by Spielberger et al. (1985). By examining the psychometric properties of this questionnaire and based on the collected data, the mean, standard deviation of alpha coefficient, percentage ratings, and standard T scores have been calculated for the scales and subscales of the Spielberger Anger Questionnaire and are reported in its practical guide. The data summarized in the practical test guide show that the alpha coefficients were 0.84 or higher for the anger control and anger scales and 0.73 or higher for the anger control, anger control, and overall anger expression scales. The simultaneous validity of the Anger Trait Scale of this questionnaire was assessed and confirmed by conducting a study on 280 undergraduate students and 270 Navy soldiers. Then, the correlation coefficient of the anger trait scale was calculated using three ideas related to hostility. These coefficients ranged from 0.32 to 0.71 for male students and from 0.13 to 0.66 for soldiers, and all coefficients were obtained statistically they were meaningful. The standardization of the anger questionnaire in Iran was performed by Khodayari-Fard et al. (2007), and its content validity was 0.88, and its reliability was 0.87. In the present study, Cronbach's alpha was equal to 0.75.

Research implementation process

In order to conduct the research, after obtaining the necessary permits from the relevant counseling center and performing the sampling process (according to what was mentioned), the selected couples (30 couples with marital conflicts) were randomly assigned to experimental and control groups (15 couples). In the experimental group and 15 couples in the control group. The experimental group received therapeutic intervention related to the combination of emotion-oriented and solution-oriented therapy for two and a half months every week for 90 minutes in 10 sessions. However, the subjects in the control group did not receive the present interventions during the study and were waiting to receive them.

Table 1. Combined emotion-oriented and solution-focused treatment protocol

Sessions	Content of sessions
First session	Familiarize and establish a therapeutic relationship, familiarize yourself with the general rules of treatment, assess the nature of the problem and relationship, evaluate each spouse's goals and expectations of treatment, give the couple a task by asking the spouses the question "What different things should your spouse do to feel?" You are considered, appreciated, and respected. "Answer and record these questions for review at the next treatment session.
2nd session	Examining the tasks done by the couple, identifying the negative interaction cycle and creating conditions in which the spouses reveal and project their negative interaction cycle, extracting effective behaviors to repeat and reinforce it, we assign the spouses to Over the next week, flip through the relationship from the beginning to the present and write down the strengths of the spouse and the relationship.
3rd session	Teaching the concept of emotion, its types and process and process in the mind, the role of emotion and emotional control in intimate relationships, creating curiosity about the spouse about other attitudes and perceptions, giving the couple homework to their daily lives until the next meeting Pay attention to pleasant (pleasure, cheerfulness, well-being, happiness, etc.) and unpleasant situations (hatred, sadness, jealousy, anxiety) and see in which situations they experience these emotions, record these situations so that To be considered in subsequent meetings.
4th session	Assessing the tasks performed by couples, focusing on emotions, attachment-oriented needs, fears and disturbances of spouses, accreditation of the spouse's various experiences as well as needs and tendencies arising from attachment-seeking, identifying therapeutic potentials and encouraging autonomy, presenting assignments in This context gives the couple "look around carefully until the next week and discover what still keeps you in the relationship".
5th session	Examine the tasks given to the couple in the previous session, access to unrecognized and underlying feelings of interactive positions, or achieve known emotions embedded in interactive situations and identify the underlying feelings of each couple. Mentioning secondary emotions and helping couples to acknowledge them, pointing to the role of focusing on positive emotions and events, taking ownership of secondary emotions and shaping primary emotions, giving spouses, until next week, the chaotic situations that Examine what they encountered and see what underlying emotions they experience in these situations.
6th session	We re-frame the task, the problem in terms of underlying feelings and attachment needs, the focus on finding solutions through individual abilities, the description of fear and the role of defense mechanisms, until the next session, the events that happen to them و .Write down what they felt scared of and what defense mechanism they used.
7th session	Encourage the identification of rejected needs and aspects of self that have been denied, draw the couple's attention to ways of interacting with each other and reflect their interactive patterns with respect and empathy, express attachment needs and identify denied needs and increase Accepting corrective experience and promoting empirical knowledge of marginalized needs and fears, and assigning aspects of experience that have not yet been absorbed, rather than exceptional aspects, namely availability and Empathize and use emotional literacy to observe each other's behavior, write it down, and report it to the next session.
8th session	Encourage the identification of rejected needs and aspects of self that have been denied, draw the couple's attention to ways of interacting with each other and reflect their interactive patterns with respect and empathy, express attachment needs and identify denied needs and increase Accepting corrective experience and promoting empirical knowledge of marginalized needs and fears, and assigning aspects of experience that have not yet been absorbed, rather than exceptional aspects, namely availability and Empathize and use emotional literacy to observe each other's behavior, write it down, and report it to the next session.
9th session	Review homework done by the couple from the previous session, create new interactive situations between couples and end old interaction patterns or facilitate the emergence of new ways to solve old communication problems, cultivate a safe environment, explore old problems and issues that are now in the light of a secure foundation Created during the treatment session, it is possible to remind the needs of attachment, strengthen new positions, discover and make the couple aware of the existence of positive exceptions in life and the existence of their spouse.
10th session	Establish and reinforce new behaviors, highlight the differences between current and old interactions, identify and support healthy interaction patterns, achieve couples a role model in their relationships, and increase availability and responsiveness. Using solution-oriented techniques such as writing, reading, and burning bad memories, evaluating the effectiveness of combination therapy, and homework, the couple is asked to surprise and make the other person happy once a week for the next 6 months.

In this research, two levels of descriptive and inferential statistics have been used to analyze the data. At the level of descriptive statistics of mean and standard deviation and at the level of inferential statistics from the Shapiro-Wilk test to check the normality of the distribution of variables, Levin test to check the equality of variances, Mochley test to check the default of data sphericity and also analysis of variance with repeated measurements were used to test the research hypothesis. The statistical results were analyzed using SPSS-23 statistical software.

3. Results

The significance level in statistical analysis was considered a minimum of 0.05 and a maximum of 0.001. Before performing an analysis of covariance, the correlation of demographic variables, including age, years of life, education, and the number of children with pre-test and post-test scores in the research groups, were compared and confirmed that there is no positive correlation between them. Table 2 presents the mean and standard deviation of the pre-test and post-test variables of anger management and marital adjustment variables in the experimental groups (compassion-focused therapy and forgiveness-based compassion therapy) and the control group.

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Table 2. **Mean and standard deviation of anger and marital adjustment in experimental and control groups in pre-test and post-test**

variable	Group	Pre-test		Post-test	
		M	SD	M	SD
Anger management	Control group	123.93	7.90	123.67	8.84
	examination Group	123.33	5.61	108.60	4.64
Marital Adjustment	Control group	36.13	11.24	36.47	9.96
	examination Group	37.27	9.35	50.27	7.64

As can be seen in Table 2, the mean of anger management and marital adjustment in the control group did not differ much between pre-test and post-test, but anger management in the experimental groups decreased. Also, the average marital adjustment in the experimental group has increased. Shapiro-Wilkes test was not significant for the normal distribution of scores of dependent variables in the pre-test and post-test stages (p> 0.05). Therefore, it can be said that the distribution of dependent variables is natural. The value of f in Levin test was not significant in the dependent variables in the two stages of pre-test and post-test. Therefore, it can be said that there was equality of variances between groups. The results of analysis of covariance for anger and marital adjustment variables are presented in Table 3.

Table 3. **Results of analysis of covariance of anger management variables and marital adjustment**

Variable	Source of changes	Total squares	Degree of freedom	Average squares	Value F	Significance	Eta coefficient	Test power
Anger management	Pre-test	1103.935	1	1103.935	22.432	0.001	0.290	0.995
	group	1876.803	3	625.601	12.712	0.001	0.409	0.996
	Error	2706.732	55	49.213				
Marital Adjustment	Pre-test	1573.793	1	1573.793	40.444	0.001	0.424	0.999
	group	1780.708	3	1780.708	15.254	0.001	0.454	0.999
	Error	2140.207	55	38.913				

According to the information in Table 3, there is a significant difference between the estimated mean scores of anger management in the subjects of the experimental and control groups (P <0.001) and the amount of differences indicates that 40.9% of the covariance of post-test scores is due to educational intervention. This means that with 99.6% power, 40.9% difference between the experimental groups and the control group was significant. Also, the pre-test variable with the effect rate of 29% is significant (P <0.001). There is a significant difference between the estimated mean of marital adjustment scores in the experimental and control groups (P <0.001) and the amount of differences indicates that 45.4% of the covariance of post-test scores is due to educational intervention and means that with 99.9% power and 45.4% difference between experimental and control groups were significant. Also, the pre-test variable with the effect rate of 42.4% is significant (P <0.001).

Table 4. **Results of Bonferroni post hoc test for pairwise comparison of research groups in anger management and marital adjustment variables**

Variable	Level	Comparative stage	The difference means	Criterion deviation error	Meaningful
Anger management	Pre-test	Post-test	-43.27	5.12	0.0001
		Follow up	-38.65	5.36	0.0001
	Post-test	Pre-test	43.27	5.12	0.0001
		Follow up	4.62	1.22	0.11
Marital Adjustment	Pre-test	Post-test	-22.81	2.41	0.0001
		Follow up	-12.25	2.25	0.0001
	Post-test	Pre-test	22.81	2.41	0.0001
		Follow up	1.18	0.58	0.49

As shown in Table 4, there is a significant difference between the mean scores of the pre-test stage and the post-test and the follow-up of anger and marital adjustment variables. This means that the combination of emotion-oriented and solution-oriented therapy has significantly changed the post-test and follow-up scores compared to the pre-test stage. Descriptive findings also showed an increase in the mean scores of marital adjustment and a decrease in the mean scores of marital anger in the experimental group. According to the data in this table, there is no significant difference between the mean scores of the post-test stage and the follow-up of anger and marital adjustment variables. This finding can be explained by the increase in adjustment scores and the decrease in marital anger scores of women with marital conflict that occurred in the post-test phase, was able to maintain this change during the follow-up period. In

summary, it can be stated that the combination of emotion-oriented and solution-oriented therapy has been able to significantly increase the mean score of adjustment and decrease the score of marital anger in women with marital conflict in the post-test phase. This effect has remained stable in the follow-up phase.

4. Discussion and Conclusion

The aim of this study was to investigate the effectiveness of a combination of emotion-oriented and solution-focused therapy on anger and marital adjustment in women with marital conflict. The first finding of the present study showed that the combination of emotion-oriented and solution-focused therapy has a significant effect on marital intimacy. Thus, this treatment has been able to improve marital intimacy in women with marital conflict. The results of the present study are consistent with the results of Arianfar and Rasouli (2017) on the effect of short-term solution-focused couple therapy on marital burnout in couples, with the findings of Sahebi Bazaz et al. (2017) on the effectiveness of emotional therapy on failure tolerance and marital adjustment, With Zeraati Shamsabadi reports (2016) on the effectiveness of emotionally oriented couple therapy on communication patterns, marital boredom and emotional self-regulation of couples, with the results of Abbasi et al.'s (2017) study on the effectiveness of short-term solution-based treatment in reducing depression and increasing marital satisfaction, and Mousavi and Badihi Zeraati (2016) on the effectiveness of emotion-oriented couple therapy on changing adult attachment style and sexual intimacy of couples. In explaining the effectiveness of combined emotion-oriented and solution-focused treatment on marital adjustment of women with marital conflicts, we must first address the determining role of emotions and express them in improving the relationships of women with marital conflict. Webb et al. (2017) found that emotional support and conflict are essential components of the marital relationship, and these factors can predict the relationship's future more powerfully than behavioral conflicts. Accordingly, emotion-oriented therapy has emerged, emphasizing the importance of these emotions. Considering the major role of emotions in attachment theory, this treatment points to the important role of emotions and emotional communication in organizing communication patterns and considers emotions as a change factor. Thus, emotional therapy helps women with marital conflict to identify and express their core needs and desires, as well as their emotional concerns about their spouse. Thus, their emotional insecurities are reduced. This process improves their marital adjustment by improving the communication and emotional patterns between women who have marital conflicts with their husbands. In addition, it can be stated that the solution-focused treatment model treats clients as competent and capable specialists who are able to solve their problems, and treatment is a process by which clients and therapists reconstruct the desired facts (Oliazadeh & Reisi, 2018). With the belief that clients can identify goals and formulate effective solutions to challenging situations, solution-oriented therapy is necessary to empower and flex clients by discovering previous solutions and exceptions to problems and encouraging clients to repeat useful and effective behaviors to achieve goals. Accordingly, by empowering women with marital conflict to solve their problems, this treatment reduces the number of communication challenges and conflicts and thus increases their marital compatibility.

The second finding of the present study showed that the combination of emotion-oriented and solution-focused treatment has a significant effect on marital anger in conflicting women. Thus, this treatment has been able to lead to the management of marital anger in women with marital conflict. The results of the present study with the results of Mohammadyari and Hosseinian (2015) on the effectiveness of short-term solution-based therapy on couple therapy, with the findings of Aghayi et al. (2015)on the effectiveness of solution-based therapy on the emotional regulation of couples, with the reports of Saemi et al. (2019) on the effectiveness of emotion-based couple therapy on marital intimacy of couples, with the results of Raisi et al. (2015) on the effectiveness of emotional couple therapy on changing communication styles of married women and reduction of couples' emotional dissatisfaction, and with Olyazadeh and Reisi Reports (2017) based on the effectiveness of solution-oriented education on marital conflicts and quality of life in couples. In the present explanation, it should be noted that anger is one of the negative desires that, when it is internalized, can damage a person's mental health and even lead to depression. In emotion therapy training, the most part of the training is on the hidden anger of the individual to the spouse, her family, the individual's own family, and any kind of anger embedded within the individual. So it is expected that by resolving these old rages, one will come to more peace and successfully control inner rages. Another explanation is that emotion-oriented therapy involves a process that changes feelings and attitudes about the person at fault. The result of this process is a reduction

in the motivation to retaliate or to alienate the wrongdoer and to eliminate negative feelings about the wrongdoer. Theorists also believe that emotion-oriented therapy represents the replacement of negative emotions with positive ones, such as compassion and benevolence. Accordingly, emotions such as compassion and benevolence and ignoring the husband's mistakes cause women with marital conflicts to perceive less negative feelings towards their husbands and thus increase their intimacy and marital compatibility. In addition, emotion-oriented therapy causes a loving and receptive attitude towards the undesirable dimensions of oneself and one's life and encourages one to be kind to oneself and others (Pullmer et al., 2019). Based on this, it can be said that emotion-based therapy causes the women in the study to have more coping and emotional skills, to be able to recreate negative emotional states to differentiate between their emotions, and to be able to have negative and annoying perceptions more desirably. Reduce their cognitive and emotional processing processes. According to this trend, the decrease in women's anger in the study can also be explained. In emotion-based therapy, conflicting women are taught not to shy away from or suppress their painful feelings. Therefore, they can know their experience in the first step and feel compassion for it. In addition, it can be stated that the solution-oriented treatment model treats clients as competent and capable specialists who are able to solve their problems, and treatment is a process by which clients and therapists reconstruct the desired facts (Oliazadeh & Reisi, 2017). With the belief that clients can identify goals and formulate effective solutions to challenging situations, solution-oriented therapy is necessary to empower and flex clients by discovering previous solutions and exceptions to problems and encouraging clients to repeat useful and effective behaviors to achieve goals. Accordingly, by empowering conflicting women to solve their problems, this treatment reduces the number of communication challenges and conflicts and thus reduces their marital anger.

The limitations of this study were: limited scope of research to women with marital conflicts referred to counseling centers in Tehran, the existence of some uncontrolled variables, such as the causes of marital conflicts of women in the study, financial status of families, number of children and their social status and not using random sampling methods. Therefore, it is suggested that to increase the generalizability of the results, at the research proposal level, this research should be conducted in other cities, regions, and communities with different cultures, other women, control of the mentioned factors, and random sampling method. In addition, it is suggested that in other studies, the effectiveness of emotion-oriented and solution-oriented combination therapy on anger and marital adjustment in other statistical communities such as divorced women, couples with marital conflicts seeking divorce, infertile couples, etc. Considering the effectiveness of the combination of emotion-oriented and solution-oriented therapy on anger and marital adjustment of women with marital conflicts, at the practical level, it is recommended that a combination of emotion-oriented and solution-focused therapy be offered to family counselors and therapists in city counseling centers and courts so that they can take practical steps to reduce anger and improve their marital adjustment by applying this treatment model to conflicting women.

5. Ethical Considerations

Compliance with ethical guidelines

All ethical principles are considered in this article. The participants were informed about the purpose of the research and its implementation stages. They were also assured about the confidentiality of their information and were free to leave the study whenever they wished, and if desired, the research results would be available to them.

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Authors' contributions

All authors have participated in the design, implementation and writing of all sections of the present study.

Conflicts of interest

The authors declared no conflict of interest

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