

Premarital Education Integrating Dialectical Behavior Therapy and Acceptance-Based Approaches in a Caregiving Relationship: Impact on Premarital Patterns and Vulnerabilities in Young Adults

Sogol Yadollahi Bastani¹, Seyed Hamid Atashpour^{1*}, Hadi Farhadi¹

¹ Department of Psychology, Isf.C., Islamic Azad University, Isfahan, Iran

*Corresponding Author: Seyed Hamid Atashpour, Ph.D., Department of Psychology, Isf.C., Islamic Azad University, Isfahan, Iran. Tel: +983135352900, Email: hamdi.atashpour@iau.ac.ir

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Abstract

Background: By recognizing the profound influence of premarital patterns and vulnerabilities on long-term marital outcomes, there is a compelling need for robust premarital education programs tailored to diverse cultural contexts.

Objectives: This study aimed to assess how premarital education, specifically approaches based on Dialectical Behavior Therapy (DBT) and acceptance-based approaches in a caregiving relationship, impacted premarital patterns and reduced vulnerabilities among young adults aged 20-40 years in Isfahan, Iran.

Methods: A three-group quasi-experimental design evaluated two distinct premarital education approaches—DBT and acceptance-based approaches in a caregiving relationship—alongside a control group. Data were collected via pre-test, post-test, and a one-month follow-up from a convenience sample of 90 young adults (30 per group) approaching marriage, attending psychological centers in Isfahan during spring and summer 2023. Participants were randomly assigned, and the Premarital Patterns and Vulnerabilities Assessment Questionnaire was used. Both intervention groups received eight 90-minute sessions. Data were analyzed using SPSS 26 with descriptive statistics and repeated measures ANOVA.

Results: Both interventions significantly improved all five premarital patterns and vulnerabilities (maladaptive communication patterns, maladaptive management patterns, couples' value system, schematic mindset, and detrimental effects of family of origin) at post-test ($P < 0.01$). DBT outperformed acceptance-based approaches in mitigating detrimental effects of family of origin at post-test ($P = 0.001$, $\eta^2 = 0.41$). At the one-month follow-up stage, DBT showed superior efficacy in addressing maladaptive communication patterns ($P = 0.009$, $\eta^2 = 0.12$) and detrimental effects of family of origin ($P = 0.001$, $\eta^2 = 0.41$) compared to acceptance-based approaches, with moderate to large effect sizes.

Conclusion: Both DBT and acceptance-based interventions effectively reduce premarital vulnerabilities and improve relational patterns in young adults. DBT demonstrated superior and sustained efficacy, particularly in addressing maladaptive communication patterns and detrimental effects of family of origin, highlighting its potential for fostering healthier relationship foundations in the Iranian cultural context.

Keywords: Premarital Education, Dialectical Behavior Therapy, Acceptance, Marriage, Family Relations

1. Background

Dysfunctional family systems contribute to a range of societal challenges, including increased mental health issues, substance abuse, and interpersonal conflicts, underscoring the need for interventions that strengthen family units.¹ Healthy family systems are fundamental to fostering well-adjusted individuals within the society, while conversely, dysfunctional families often precipitate a myriad of social challenges. Without concerted efforts to strengthen family units, societal problems are likely to escalate. Contemporary families are shaped by distinct norms, such as evolving gender roles and expectations for mutual emotional support, and their sustained well-being

is highly valued.² However, the longevity of these family structures is largely contingent upon the quality of spousal interactions.

In today's dynamic and complex society, marriage requires careful preparation to navigate challenges such as shifting societal expectations and diverse cultural influences, which directly influence the enduring nature of marital unions.³ Issues stemming from a lack of readiness can render relationships vulnerable to escalating, unresolved conflicts.³ Consequently, a critical prerequisite for successful marriage involves identifying and addressing maladaptive patterns prior to entering married life. This proactive approach is considered vital for preventing

divorce, ensuring marital stability, and refining partner selection criteria.⁴ These significant premarital patterns and vulnerabilities are typically classified into five core areas: maladaptive communication patterns, maladaptive management patterns, incongruent couple value systems, schematic mindsets, and the detrimental effects of the family of origin.⁵

Couple relationships are fundamentally shaped by the communication patterns that emerge and solidify through repeated interactions, guiding partners' behaviors over time.⁶ Problematically, maladaptive communication is a pervasive and destructive challenge in failing marriages, often leaving critical issues unresolved and fueling persistent conflict.⁷ Similarly, ineffective relationship management can escalate disputes, eroding mutual understanding, intimacy, and satisfaction, replacing them with distressing interactions and dissatisfaction.⁸ Malik et al.⁹ identifies couple conflict as arising from misaligned needs, egocentricity, mismatched desires, and irresponsible behaviors that undermine marital love's intimate core.

Beyond interpersonal communication, a couple's value system is deeply rooted in each partner's cultural background, shaping their relational dynamics. Misalignments in core values and beliefs frequently result in discordant expectations and norms.¹⁰ Additionally, schematic mindsets, originating from childhood experiences and maladaptive schemas—entrenched cognitive and emotional frameworks that guide perceptions and behaviors—significantly influence individual emotional needs, temperaments, and attachment patterns, acting as an inherited legacy within relationships.¹¹ Family behavioral tendencies substantially affect relational adjustment, particularly within marital contexts.¹² Partners entering marriage bring forward experiences and expectations from their family of origin, which profoundly shape subsequent intimate interactions and approaches to conflict resolution. Unresolved issues from these early family dynamics may perpetuate ongoing conflicts.¹³ Furthermore, deficiencies in parental communication often contribute to feelings of anxiety, isolation, and loneliness within family systems.¹⁴ Marital discord and divorce have far-reaching consequences for individuals, their children, extended families, and the society at a larger scale, underscoring the need for robust preventive and interventional strategies.¹⁵ Such programs are essential for fostering resilient marriages by addressing factors that contribute to marital breakdown.

Dialectical Behavior Therapy (DBT), a specialized cognitive-behavioral therapy, emerged from the third wave of behaviorism, emphasizing psychosocial treatment dimensions. This adaptable, hierarchical approach is applicable across diverse populations.¹⁶ DBT integrates emotional, cognitive, and behavioral techniques, aiding clients in managing intense emotions, reducing self-centered behaviors, and enhancing interpersonal relationships. As an integrative model, DBT teaches individuals to

identify and synthesize internal or environmental conflicts for effective resolution, highlighting skill training, acceptance, and emotion validation.¹⁷ Evidence supports DBT's relational utility. Jamshidi et al.¹⁸ revealed that DBT increased marital satisfaction and resilience in women seeking divorce. Badanfiroz et al.¹⁹ concluded DBT enhanced intimacy, while Iri et al.²⁰ identified it as effective for improving marital quality, preventing divorce, and reducing emotional detachment.

Acceptance in a couple's caregiving relationship, a structured approach inspired by the Couple CARE program, focuses on fostering mutual support, empathy, and conflict resolution to enhance romantic relationships.²¹ This program aims to enhance romantic family relationships and resolve interpersonal marital issues. It operates on the premise that individuals entering marriage bring unique personalities, values, and expectations, leading to potential challenges from divergent individual and social factors (e.g., beliefs, status). Thus, premarital education, such as the Couple CARE program,²² is crucial for aligning expectations and values. Structured around social support, conflict management, and forgiveness training, the program's efficacy is well-supported. Halford et al.²³ found it improved young couples' relationship beliefs, marital expectations, satisfaction, and communication. Similarly, Hashemi et al.²⁴ demonstrated that acceptance in a caregiving relationship reduced negative communication, boosted family skills, fostered greater family interactions, and diminished marital conflicts.

While existing research highlights the impact of premarital counseling on marital stability and satisfaction, there's a notable gap in studies comparing the effectiveness of premarital education rooted in DBT versus acceptance in a caregiving relationship. For example, studies like Halford et al.²³ and Jamshidi et al.¹⁸ have focused on individual intervention efficacy but do not compare these approaches directly. Specifically, no prior research has explored their differential effects on premarital patterns and vulnerabilities among young adults nearing marriage. This critical gap suggests that the findings of this study could offer novel and highly valuable insights for this population.

2. Objectives

This research aimed to compare the effectiveness of premarital education based on DBT and acceptance-based approaches in a caregiving relationship on premarital patterns and vulnerabilities among young adults preparing for marriage in Isfahan, Iran. We hypothesized that both interventions would significantly improve premarital patterns and reduce vulnerabilities compared to a control group, with DBT potentially showing greater efficacy in addressing complex relational issues, such as maladaptive communication and detrimental effects of family of

origin, due to its focus on emotion regulation and interpersonal skills.

3. Methods

3.1. Design and Participants

This study utilized a three-group quasi-experimental design to evaluate two distinct premarital education approaches: one based on DBT and the other on acceptance within a caregiving relationship. A control group was also included. Data collection occurred across three phases: pre-test, post-test, and a one-month follow-up. The target population comprised young adults who were close to their marriage ceremony who sought services at family counseling centers in Isfahan during spring and summer 2023. From this population, we recruited a convenience sample of 90 participants, with 30 individuals assigned to each of the three groups via simple random assignment.

3.2. Inclusion and Exclusion Criteria

Inclusion criteria for participation were: no previous marriage, absence of acute or chronic psychological or physical illnesses, age between 20 and 40 years, at least a high school education, and no concurrent psychological treatments. Exclusion criteria involved developing an acute or chronic mental or physical illness, marrying during the intervention (as it could confound the focus on premarital dynamics), failing to complete assigned homework, or missing more than two treatment sessions.

3.3. Ethical Considerations

Throughout the study, strict ethical principles were maintained, including obtaining informed consent from all participants, ensuring confidentiality, restricting data use solely to research objectives, guaranteeing participants' complete freedom to withdraw, and providing detailed results upon request. Furthermore, the control group was offered the intervention after the experimental groups completed their treatment.

3.4. Research Instrument

3.4.1. Premarital Patterns and Vulnerabilities Assessment Questionnaire

Developed by Rostami et al. in 2019, this questionnaire addresses the crucial need to identify individual and interpersonal patterns, alongside vulnerabilities, during the engagement and premarital phases. Its design uniquely considers Iran's diverse cultural context and aims to enhance the quality of premarital counseling. The instrument contains 79 items structured around five key themes related to premarital dynamics: Maladaptive communication patterns (19 items), maladaptive management patterns (17 items), couples' value system (12 items), schematic mindset (21 items), and detrimental effects of the family of origin (10 items). Participants

respond using a five-point Likert scale, ranging from "1 = Strongly Disagree" to "5 = Strongly Agree." Importantly, the questionnaire does not produce a single total score; instead, it provides independent measures for each of the five identified factors. Cronbach's alpha coefficient was calculated to assess the instrument's internal consistency. The questionnaire exhibited strong reliability for its various factors: 0.92 for maladaptive communication patterns, 0.90 for maladaptive management patterns, 0.91 for couples' value system, 0.89 for schematic mindset, and 0.87 for the detrimental effects of the family of origin.²⁵

3.5. Procedure

To conduct this study, we first coordinated with family counseling clinics in Isfahan. A subsequent call for participation garnered interest from 120 young adults approaching marriage. Following the administration of the Premarital Patterns and Vulnerabilities Questionnaires, 90 participants were selected based on the established inclusion criteria. These individuals were then randomly assigned (30 per group) to either the experimental or the control group via a lottery system without additional matching procedures. During the intervention phase, both the DBT and acceptance in a caregiving relationship programs were delivered. Each program consisted of eight 90-minute weekly sessions, spanning eight consecutive weeks, followed by a one-month post-treatment follow-up session. Attendance was monitored through session logs completed by therapists, and homework completion was tracked via participant submissions reviewed weekly by facilitators. All sessions were facilitated by experienced therapists, each possessing over five years of clinical experience in premarital counseling and specialized training in DBT or acceptance-based approaches. The control group received no therapeutic intervention until the experimental groups completed their respective treatments. Ultimately, all three groups were compared at pre-test, post-test, and follow-up to assess the effectiveness of the educational interventions. A detailed summary of both DBT and acceptance in a caregiving relationship has been presented in Tables 1 and 2.

3.6. Data Analysis

Data analysis for this study involved both descriptive and inferential statistical methods. Descriptive statistics, specifically means and standard deviations, were calculated to summarize the data. At the inferential level, the Shapiro-Wilk test was employed to assess the normality of variable distribution. Mauchly's test was then utilized to examine the assumption of sphericity, as well as considerations regarding the equality of the variance-covariance matrix, which are pertinent for repeated measures designs. Subsequently, a repeated measures ANOVA was conducted to investigate significant differences

Tables 1. Summary of Dialectical Behavior Therapy Sessions

Session	Content
1	Introduction to participants, session goals, and group rules; outlining expectations; explaining group procedures, attendance, session frequency, and duration; defining dialectics; introducing DBT and the concept of mindfulness.
2	Training in present-moment focus and separating thoughts from emotions and bodily sensations; understanding the three states of mind (Rational Mind, Emotional Mind, and Wise Mind); clarifying the distinction between description and judgment, and transforming judgment into observation of conflict; teaching "What" skills (Observe, Describe, Participate) and "How" skills (Non-judgmentally, One-mindfully, Effectively) in mindfulness.
3	Teaching distress tolerance skills: attention shifting/distraction, self-soothing, imagery of a safe place, conscious breathing, the "STOP" technique for crisis management and commitment to action; preventing impulsive behaviors; observing and managing harmful urges.
4	Practicing living in the present moment; developing a relaxation plan; coping with tensions using self-encouraging coping thoughts and affirmative self-talk.
5	Understanding and accepting emotions; reducing vulnerability to negative emotions; balancing thoughts and feelings; increasing positive emotions; teaching self and partner acceptance, including relationship awareness, self-awareness, mindful self-attention, navigating emotional and rational self-states, and understanding the role of anger in relationships.
6	Overcoming barriers to healthy emotions; reducing physical vulnerability to distressing emotions; non-judgmental mindful attention to emotions; emotional exposure; acting opposite to intense emotional urges; increasing positive emotions.
7	Teaching interpersonal effectiveness skills: assertive listening, saying "no," managing resistance and conflict; how to validate one's partner, understanding a partner's problems and mistakes; verbal and behavioral validation; training in clear expression of feelings, including identifying vague desires and feelings, and avoiding indirect communication, underestimation, or overestimation of desires.
8	Training in negotiation and interpersonal problem analysis; utilizing conflict positively to foster intimacy; teaching problem-solving and discussion techniques, including problem management, problem identification, problem analysis, practical skill review, and final summary.

Table 2. Summary of Acceptance in the Caregiving Relationship Sessions

Session	Content
1	Introduction to participants, session goals, and group rules; outlining expectations; explaining group procedures, attendance, session frequency, and duration. Training focused on communication expectations, relational goals, and self-change strategies for achieving communication goals within the marital bond.
2	Training on interaction models, effective speaking and listening skills; self-assessment of interaction patterns; understanding and responding to emotional bids; fostering self-change within interactions.
3	Education on caregiving experiences, achieving individual balance, balancing family and other life activities; exploring managed support; and facilitating self-change to enhance intimacy.
4	Training on valuing individual differences; promoting effective interaction during conflict; providing guidelines for conflict management; and encouraging self-change in navigating conflicts.
5	Education on premarital vulnerabilities; understanding the dimensions of forgiveness; exploring relational dynamics through interaction; and encouraging self-change for accepting conflicts.
6	Training on anticipating changes; developing strategies for planning for future changes; and early identification of potential communication problems.
7	Emphasis on attention to maintaining and preserving relationships; fostering self-change to imbue future prospects with meaning.
8	Comprehensive summary and conclusion of the therapeutic intervention.

across time points between the experimental and control groups. For detailed pairwise comparisons among these groups, Bonferroni post-hoc tests were applied. All statistical computations were performed using SPSS-26 software.

4. Results

Demographic analysis indicated that the three groups were comparable in terms of gender, age, and educational attainment, supporting the validity of the quasi-experimental design. Regarding gender distribution, the DBT group comprised 80% (n = 24) females and 20% (n = 6) males. The acceptance group consisted of 60% (n = 18) females and 40% (n = 12) males, while the control group exhibited a composition of 63.33% (n = 19) females and 36.67% (n = 11) males. In terms of educational attainment, the DBT group's breakdown included 46.67% (n = 14) holding Bachelor's degrees, 43.33% (n = 13) with Master's degrees, and 10% (n = 3) possessing Doctorates. The acceptance group presented a comparable educational profile: 46.67% (n = 14) Bachelor's, 43.33% (n = 13) Master's, and 13.33% (n = 4) Doctorates. The control group showed 53.33% (n = 16) with Bachelor's

degrees, 33.33% (n = 10) with Master's, and 13.33% (n = 4) with Doctorates. The mean age and standard deviation for each group were as follows: DBT group (28.45 ± 6.65 years), acceptance group (26.29 ± 5.38 years), and control group (28.90 ± 5.38 years).

Table 3 provides a comprehensive overview of the means and standard deviations for various premarital patterns and vulnerabilities, specifically including maladaptive communication patterns, maladaptive relationship management patterns, couples' value system, schematic mindset, and the detrimental effects of the family of origin. These data are segmented by the three distinct research groups—the DBT group, the acceptance in a caregiving relationship group, and the control group—and tracked across three assessment phases: pre-test, post-test, and follow-up. An examination of these mean scores revealed that both the DBT and acceptance in a caregiving relationship groups exhibited more significant improvements in premarital patterns and vulnerabilities during both the post-test and follow-up assessments when compared to the control group.

For the data analysis in this study, the Shapiro-Wilk test was employed to assess the normality of variable

Table 3. Descriptive Statistics of Premarital Patterns and Vulnerabilities

Premarital pattern/vulnerability	Stage	DBT group	Acceptance in a caregiving relationship group	Control group
		Mean \pm SD	Mean \pm SD	Mean \pm SD
Maladaptive communication patterns	Pre-test	57.36 \pm 4.77	56.90 \pm 5.59	55.03 \pm 5.69
	Post-test	52.16 \pm 4.63	53.60 \pm 3.08	56.43 \pm 5.11
	Follow-up	52.26 \pm 5.07	55.60 \pm 4.90	56.93 \pm 4.00
Maladaptive management patterns	Pre-test	51.46 \pm 5.93	53.23 \pm 6.51	54.03 \pm 4.41
	Post-test	49.66 \pm 3.38	50.96 \pm 4.62	54.33 \pm 5.73
	Follow-up	46.56 \pm 6.48	47.33 \pm 6.01	56.66 \pm 6.25
Couples' value system	Pre-test	42.43 \pm 4.05	41.00 \pm 6.16	41.50 \pm 3.84
	Post-test	34.4 \pm 4.19	35.16 \pm 3.02	40.83 \pm 4.40
	Follow-up	34.26 \pm 4.33	34.73 \pm 4.77	40.03 \pm 5.39
Schematic mindset	Pre-test	70.60 \pm 6.83	68.23 \pm 6.86	69.16 \pm 7.04
	Post-test	60.43 \pm 4.30	62.36 \pm 5.34	70.30 \pm 6.58
	Follow-up	60.16 \pm 4.65	61.53 \pm 7.52	68.30 \pm 6.43
Detrimental effects of the family of origin	Pre-test	34.36 \pm 5.03	36.43 \pm 5.25	34.63 \pm 3.76
	Post-test	25.60 \pm 2.97	28.50 \pm 3.91	34.43 \pm 3.27
	Follow-up	26.53 \pm 4.12	30.03 \pm 4.06	33.83 \pm 3.28

Table 4. Results of Between-subjects Effects Analysis for Premarital Patterns and Vulnerabilities

Premarital pattern/vulnerability	SS (Sum of Squares)	df	MS (Mean Square)	F	P	η^2
Maladaptive communication patterns	308.11	2	154.06	4.11	0.032	0.12
Maladaptive management patterns	1273.97	2	636.99	12.66	0.001	0.25
Couples' value system	1060.89	2	530.45	14.44	0.001	0.27
Schematic mindset	1938.26	2	969.13	10.94	0.001	0.22
Detrimental effects of family of origin	1426.40	2	713.20	26.86	0.001	0.41

distribution, thereby ensuring that the data met the necessary assumptions for subsequent statistical analyses. Mauchly's test confirmed sphericity for all variables ($P > 0.05$), indicating no need for adjustments in the repeated measures ANOVA. Furthermore, Mauchly's test was conducted to examine the assumption of sphericity and address considerations regarding the equality of the variance-covariance matrix. These preliminary checks are critical for upholding the validity of the repeated measures ANOVA, which was utilized to investigate significant differences across time points between the experimental and control groups.

Table 4 summarizes the findings from the between-subjects effects analysis, which investigated the main effect of group on several premarital patterns and vulnerabilities. The analysis revealed a statistically significant main effect for group across all evaluated patterns and vulnerabilities. Specifically, significant differences were observed among the groups, with both DBT and acceptance-based groups showing lower mean scores (indicating improvement) compared to the control group for maladaptive communication patterns ($F = 4.11$, $P = 0.032$, $\eta^2 = 0.12$), maladaptive management patterns ($F = 12.66$, $P = 0.001$, $\eta^2 = 0.25$), couples' value system ($F = 14.44$, $P = 0.001$, $\eta^2 = 0.272$), schematic mindset ($F = 10.94$, $P = 0.001$, $\eta^2 = 0.221$), and detrimental effects of family of origin ($F = 26.86$, $P = 0.001$, $\eta^2 = 0.41$). Collectively, these results indicate overall significant variations in these premarital indicators across the DBT, acceptance in a caregiving relationship, and control groups.

Table 5 presents the findings from the Bonferroni post-hoc test at post-test, comparing mean scores across groups for each premarital pattern and vulnerability. At

this stage, both the DBT group and the acceptance in a caregiving relationship group demonstrated significantly reduced mean scores compared to the control group across most variables, indicating immediate improvements following the interventions. Specifically, the DBT group showed significant differences from the control group across all five factors (all $P = 0.001$). Similarly, the acceptance group also exhibited significant improvements compared to the control group for all factors (all $P < 0.05$, with $P = 0.013$ for maladaptive communication patterns). However, no significant differences were observed between the DBT and acceptance in a caregiving relationship groups for maladaptive communication patterns, maladaptive management patterns, couples' value system, and schematic mindset (all $P > 0.05$), suggesting comparable immediate effects of the two interventions on these specific areas. Notably, DBT showed significantly greater improvement than the acceptance group for detrimental effects of family of origin ($P = 0.001$, mean difference = 2.90), indicating a stronger immediate impact in this area.

Table 6 presents the results of the Bonferroni post-hoc test at the one-month follow-up stage, providing insights into the sustained effects of the interventions. The DBT group maintained significant improvements compared to the control group across all five premarital patterns and vulnerabilities (all $P = 0.001$). The acceptance in a caregiving relationship group also demonstrated sustained significant differences from the control group for maladaptive management patterns, couples' value system, schematic mindset, and detrimental effects of family of origin (all $P = 0.001$), but not for maladaptive communication patterns ($P = 0.291$). Furthermore, a significant difference was observed between the acceptance

and DBT groups for maladaptive communication patterns ($P = 0.009$) and detrimental effects of family of origin ($P = 0.001$), suggesting differential sustained effects in these specific areas. Conversely, for maladaptive management

patterns, couples' value system, and schematic mindset, no significant differences were found between the two intervention groups (all $P > 0.05$), indicating comparable long-term effects for these particular factors.

Table 5. Bonferroni Post-hoc Test for Pairwise Comparison of Mean Scores of Premarital Patterns and Vulnerabilities Research Groups at Post-test

Premarital pattern/vulnerability	Groups	Mean difference	SE	P
Maladaptive communication patterns	DBT vs Control	-4.26	1.12	0.001
	Acceptance vs Control	-2.83	1.12	0.013
	Acceptance vs DBT	1.42	1.12	0.206
Maladaptive management patterns	DBT vs Control	-4.66	1.19	0.001
	Acceptance vs Control	-3.36	1.19	0.006
	Acceptance vs DBT	1.30	1.19	0.279
Couples' value system	DBT vs Control	-6.43	1.01	0.001
	Acceptance vs Control	-5.6	1.01	0.001
	Acceptance vs DBT	0.77	1.01	0.453
Schematic mindset	DBT vs Control	-9.86	1.48	0.001
	Acceptance vs Control	-7.93	1.48	0.001
	Acceptance vs DBT	1.93	1.48	0.195
Detrimental effects of family of origin	DBT vs Control	-8.83	0.97	0.001
	Acceptance vs Control	-5.93	0.97	0.001
	Acceptance vs DBT	2.90	0.97	0.001

Table 6. Bonferroni Post-hoc Test for Pairwise Comparison of Mean Scores of Premarital Patterns and Vulnerabilities across Research Groups at Follow-up

Premarital pattern/vulnerability	Groups	Mean difference	SE	P
Maladaptive communication patterns	DBT vs Control	-4.66	1.25	0.001
	Acceptance vs Control	-1.3	1.25	0.291
	Acceptance vs DBT	3.33	1.25	0.009
Maladaptive management patterns	DBT vs Control	-8.10	1.50	0.001
	Acceptance vs Control	-7.33	1.50	0.001
	Acceptance vs DBT	0.77	1.50	0.611
Couples' value system	DBT vs Control	-5.76	1.20	0.001
	Acceptance vs Control	-5.30	1.20	0.001
	Acceptance vs DBT	0.47	1.20	0.703
Schematic mindset	DBT vs Control	-8.43	1.60	0.001
	Acceptance vs Control	-7.06	1.60	0.001
	Acceptance vs DBT	1.36	1.60	0.396
Detrimental effects of family of origin	DBT vs Control	-7.30	0.96	0.001
	Acceptance vs Control	-3.80	0.96	0.001
	Acceptance vs DBT	3.50	0.96	0.001

5. Discussion

This study investigated the effectiveness of premarital education, specifically examining approaches rooted in DBT and acceptance-based approaches in a caregiving relationship, on key premarital patterns and vulnerabilities among young adults preparing for marriage. The findings indicate that both interventions demonstrated efficacy in ameliorating premarital patterns and vulnerabilities compared to the control group, with DBT showing superior efficacy in specific areas, such as maladaptive communication patterns and detrimental effects of family of origin, at post-test and follow-up. This outcome can be attributed to several mechanisms inherent in DBT. Firstly, the DBT approach is posited to enhance individuals' self-efficacy in navigating conflicts and challenges, thereby reducing stress-inducing behaviors and fostering a sustained sense of resilience in daily life.²⁶ Within this therapeutic framework, a core focus is placed on analyzing and reframing evaluations of life situations, underlying assumptions, interpretations, ruminative thoughts, and concerns stemming from observed realities. Through the strategic application of DBT's validation techniques, not only is empathic understanding communicated, but the

legitimacy of individuals' emotions, cognitions, and actions regarding maladaptive relationship management patterns and fear of marriage is also explored and affirmed.¹⁷

Secondly, the emphasis on acceptance within these approaches plays a crucial role in mitigating rejection sensitivity, fears of abandonment and separation, and negative emotions within interpersonal contexts. Rejection sensitivity, a trait closely linked to abandonment fears and an intolerance of solitude,¹⁹ is directly addressed. Furthermore, challenging interpersonal and communicative situations are managed through two key emotion regulation strategies: situation selection and situation modification. These strategies enable emotional modulation via stimulus control, either by avoiding or altering situations that evoke undesirable emotions. To bolster effective situation selection, DBT educates participants on creating pros and cons lists to guide their actions. For enhancing situation modification, DBT integrates problem-solving skills, aiming to develop or modify strategies to eliminate, reduce, or avoid emotionally problematic scenarios.²⁷

In contrast, the acceptance-based approach, rooted in the Couple CARE program, facilitates change through

fostering mutual empathy, conflict management, and appreciation of individual differences.²¹ By emphasizing skills such as effective listening, responding to emotional bids, and valuing differences, this approach helps participants develop a sense of security and mutual understanding, which contributes to reductions in premarital vulnerabilities like incongruent value systems and maladaptive management patterns.²³

Finally, the effectiveness of the DBT approach can also be contextualized within the integrated relational maintenance model.²⁰ This model underscores the significance of intentional relationship maintenance, conceptualizing it as a shared responsibility. It delineates proactive strategies for both preventing relational issues (threat reduction) and strengthening the relationship (maintenance), both vital components for any comprehensive relationship development program. Within the realm of threat reduction, individual tasks involve disengaging from alternative partners, fostering positive illusions or idealizations, and cultivating positive attributions. Concurrently, interactive tasks encompass conflict management, forgiveness, sacrifice, facilitation, and dyadic coping.

Moreover, recognizing that individuals with a fear of marriage, often influenced by detrimental patterns, demonstrate a diminished inclination toward considering marriage and family formation as vital developmental tasks, underscores the imperative to educate them on a values system for the modification of their life goals and values. DBT facilitates this process by guiding participants to align their actions with personal and relational values through skills like mindfulness and emotion regulation, enabling them to re-evaluate and prioritize life goals that support marital commitment.¹⁷ Emphasizing the critical role of examining life goals and values, aligning committed actions with personal values lays the groundwork for a more satisfying life. This process of revisiting life values and goals facilitates a psychological re-evaluation, enabling individuals to pinpoint areas of their lives where perceived ideal importance is high but actual effort is comparatively low.²⁷

Another research finding indicated that acceptance in a caregiving relationship education proved effective in addressing premarital patterns and vulnerabilities among young adults approaching marriage. Given that single men and women often lack sufficient information regarding the nature of marriage, premarital preparation programs should provide opportunities for participants to evaluate their marital goals. Conversely, while young adults do not necessarily reject marriage, their fear of marriage and its associated expectations can lead to concerns that poor partner selection may result in frustration and disappointment.²¹ Therefore, premarital interventions for young adults should directly assist

individuals in clarifying their own and their partner's meaning and attitudes towards marriage.

In the present study, participants, following the acceptance in a caregiving relationship education, engaged in exploring areas of stress in partner selection. Considering that interactional and communication problems are primary contributors to marital tension and conflict, often reflecting underdeveloped communication skills,²³ it is plausible that providing training on interaction models, speaking and listening, self-assessment of interaction, emotional bids, and self-change in interaction—all within the framework of premarital interventions like the acceptance in a caregiving relationship program—can foster a sense of security, belonging, a positive personal identity, a realistic view of love, constructive relationships, mutual respect, feelings of worth, competence, and a sense of personal growth. This is achieved through emphasis on evaluation, empathy building, communication/conflict management, relationship maintenance, and teaching the value of individual differences in conflict formation and resolution. This process enables individuals to acquire essential skills for relationship trust and confidence in a stable, long-term relationship by gaining knowledge about their romantic partner during the dating phase and engaging in related processes such as mutual self-disclosure and sharing past relationship experiences, which are crucial for relationship development over time. Consequently, when individuals learn about marital conflicts and pre-marriage coping strategies, they develop a more realistic perspective on marriage.

Furthermore, within the context of premarital education, it is essential to examine the nature of "my system" and "my partner's system," addressing how these systems inform individual and shared beliefs and ways of life, and how these unique systems interact within romantic relationships. This foundational understanding is conceptualized as reciprocal empathy and an enhanced mutual understanding.²⁸

The study's reliance on a convenience sample of 90 participants from Isfahan limits generalizability to broader populations with diverse cultural or socio-economic backgrounds. Additionally, the study did not control for potential confounding variables, such as participants' motivation levels, which could influence intervention outcomes. Additionally, the one-month follow-up period may not capture long-term effects of the interventions, potentially underestimating their sustained impact on premarital patterns and vulnerabilities, necessitating further research with extended follow-up durations.

The findings have significant implications for premarital education programs and policy, particularly in cultural contexts like Iran. Incorporating DBT, with its emphasis on emotion regulation and interpersonal

effectiveness, into premarital education can enhance relational resilience and address complex family-of-origin issues. Similarly, acceptance-based programs, by fostering empathy and conflict management, offer valuable tools for building mutual understanding. Policymakers and clinicians should consider integrating these evidence-based approaches into national family support initiatives to promote marital stability and reduce divorce rates.

6. Conclusion

This study clearly shows that both DBT and acceptance-based interventions effectively improved a wide array of premarital patterns and vulnerabilities right after the program. These included problematic communication and management styles, value system issues, ingrained thought patterns, and the negative influence of one's family of origin. A closer look at the two approaches revealed subtle but important differences. DBT proved more effective than acceptance training in tackling the detrimental effects of the family of origin, a benefit observed immediately after the intervention and sustained at the one-month follow-up. Furthermore, DBT's lasting advantages also extended to improving maladaptive communication patterns at follow-up. These results highlight how crucial it is to incorporate specialized therapeutic elements into premarital education to build stronger relationship foundations, especially emphasizing DBT's unique ability to address complex relationship and family challenges.

Research Highlights

What Is Already Known?

Premarital education enhances marital stability by addressing maladaptive patterns. DBT improves relationship satisfaction and resilience, while acceptance-based programs like Couple Care enhance communication and reduce conflict. Prior research confirms their efficacy but lacks comparative studies on their impact on specific premarital vulnerabilities in young adults.

What Does This Study Add?

This study demonstrates that DBT and acceptance-based interventions significantly improve premarital patterns and vulnerabilities, with DBT showing superior efficacy in mitigating maladaptive communication and family of origin effects, sustained at one-month follow-up. It provides novel insights by comparing these approaches, highlighting DBT's unique potential for building stronger premarital relationship foundations.

Author Contributions

SYB: Developed the study concept and design, collected data, analyzed and interpreted data, and performed statistical analysis. SHA: Provided administrative, technical, and material support, and oversaw the study. HF: Critically reviewed the manuscript for significant intellectual contributions.

Conflict of Interest Disclosures

All authors declared that they have no conflict of interest.

Ethical Approval

The study was approved by the Ethical Committee of Islamic Azad University-Isfahan Branch (code: IR.IAU.KHUISF.REC.1403.304).

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