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Original Article

Impact of Group Reality Therapy Glaser on Self-Esteem and Depression of Betrayed Women: An Experimental Study with Control Group

Shiva Moradi[1], MSc; Hossein Komeili Sani[1]*, MSc; Bahman Dashtbozorgi[1], MSc; Saeed Ghanbari[2], PhD

[1] Department of Psychiatric Nursing, Faculty of Nursing and Midwifery, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran.
[2] Department of Biostatistics, Faculty of Health, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran.

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ABSTRACT

Background: Marital infidelity is one of the most challenging issues in married life, often leading to adverse psychological outcomes such as depression and diminished self-esteem. This study aimed to examine the impact of Glaser's group reality therapy on self-esteem and depression in betrayed women.

Methods: This experimental study employed a pre-test–post-test design with a control group. Thirty-six women referred to counseling centers under the supervision of the Social Welfare Organization were randomly assigned to either the intervention or control group. The intervention group participated in ten 90-minute sessions of reality therapy. Data were collected using the Marital Adjustment Scale, Rosenberg Self-Esteem Scale, and Beck Depression Inventory. Statistical analyses were performed using SPSS software version 22, with a significance level set at $p < 0.05$.

Results: No significant differences were observed between the two groups regarding demographic variables. Similarly, pre-intervention scores for self-esteem ($p = 0.756$) and depression ($p = 0.875$) showed no significant difference between the groups. However, post-intervention analysis revealed a significant improvement in self-esteem and a significant reduction in depression scores in the intervention group compared to the control group ($p < 0.001$).

Conclusion: Group reality therapy based on Glaser's model effectively enhances self-esteem and reduces depression among women affected by marital infidelity. It is recommended that relevant authorities incorporate such programs into support services for couples during their married life.

*Corresponding author: Hossein komeili Sani, Department of Psychiatric Nursing, Faculty of Nursing and Midwifery, Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran, **E-mail:** komeili-h@ajums.ac.ir; **Tel:** 00989163063476

Introduction

Marital infidelity is a common and serious issue that affects couples worldwide. According to some estimates, 20% to 40% of married individuals in the United States have engaged in extramarital affairs at some point in their lives [1]. The reported prevalence of marital infidelity varies across studies and countries, with factors such as concealment, secrecy, fear of dishonor, and social conservatism influencing individuals' willingness to disclose such behavior [2]. Earlier studies suggested that infidelity occurred in 50% of all married men and 26% of all married women by the age of forty [3]. However, more recent research presents a somewhat different picture, reporting that 60% to 70% of men and 50% to 60% of women engage in extramarital affairs and cheating during marriage [4].

Infidelity can have devastating consequences for those involved, leading to emotional distress, depression, anxiety, diminished self-esteem, guilt, and shame. It can also severely damage the marital relationship, resulting in conflict, dissatisfaction, distrust, and even divorce [5, 6].

Infidelity can be defined as a breach of the marital contract regarding sexual and emotional exclusivity. However, perceptions and definitions of infidelity vary depending on cultural, religious, and personal values [7]. Some individuals may view only physical intimacy as infidelity, whereas others may also include emotional intimacy or online interactions [8]. Furthermore, the motives and reasons for infidelity differ across individuals and circumstances [5, 6]. Common contributing factors include dissatisfaction with the marital relationship, poor communication, unmet emotional or sexual needs, boredom, curiosity, opportunity, or even revenge [9].

The discovery or disclosure of infidelity can be a traumatic event for both spouses, but women often suffer more due to their emotional state [10]. Betrayed women may experience a range of negative emotions, including anger, sadness, fear, confusion, guilt, and shame. They may also develop symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), or even suicidal thoughts [11]. Women who have engaged in infidelity may likewise feel guilt, regret, remorse, or ambivalence, and they may struggle with the decision to end the affair or continue the marriage [12]. Among these consequences, a review of the literature indicates that depression and its negative impact on self-esteem are particularly common [11, 13]. Depression can further lead individuals to withdraw from social interactions or activities that might otherwise enhance their self-esteem [14]. The interplay between low self-esteem and depression tends to be chronic, mirroring the enduring psychological impact of infidelity itself [15].

The impact of infidelity on the marital relationship can be profound and long-lasting. Trust and intimacy between partners may be severely damaged or lost [5, 6]. Communication and cooperation can become reduced or impaired, while conflict and hostility may escalate. Likewise, marital satisfaction and commitment may decrease, and the risk of separation or divorce significantly increases [8].

Therefore, it is important to identify effective strategies to support couples coping with infidelity. One such approach is group reality therapy (GRT), which is based on the principles of choice theory and reality therapy [16]. GRT helps clients take responsibility for their choices and actions while evaluating how effectively they are meeting their needs and fulfilling their "quality world." It also emphasizes improving current relationships through positive behaviors that foster connection rather than disconnection from others [17]. GRT aims to enhance communication, responsibility, commitment, and satisfaction within relationships. Furthermore, it assists couples in coping with the emotional pain and trauma caused by infidelity and supports the rebuilding of trust and intimacy [18].

GRT is an adaptation of reality therapy for group settings. It involves a facilitator who guides group members through a series of steps: establishing rapport, focusing on the present situation rather than history, identifying the wants and needs of each member, evaluating current behaviors and choices, developing plans for change and improvement, implementing those plans, and finally evaluating outcomes and providing feedback [19, 20]. GRT has been applied to various populations and issues, including substance abuse, domestic violence, sexual dysfunction, juvenile delinquency, academic achievement, and organizational management [17, 18]. However, there is limited empirical evidence regarding the effectiveness of GRT for couples—particularly women—who have experienced infidelity [21]. Furthermore, few reality therapy interventions have addressed the chronic consequences of betrayal, such as depression and diminished self-esteem. Most existing studies on GRT have focused on different populations or issues and have employed varying outcome measures and research designs [21, 22]. Therefore, this study aimed to investigate the impact of GRT on depression and self-esteem in women who have experienced infidelity.

Methods

Design

The present study was an experimental design with a control group, employing a pre-test and post-test format [23]. The statistical population consisted of all married women living in Ahvaz who had experienced marital infidelity, were in permanent or temporary marriages, and had been referred to counseling centers under the supervision of the Ahvaz Welfare Organization for assistance with marital issues.

Participant & Sampling

The sample size was calculated using MedCalc statistical software, with a power of 90% and an error rate of 5%, resulting in a required sample of 32 participants (16 per group). To account for potential attrition during follow-up, 20% was added to the calculated sample size, increasing it to 18 participants per group. Inclusion criteria for participation were: dysfunctional marital relationships defined as a Marriage Adjustment Scale (MAS) score below 100; no emotional and sexual relationship with the spouse for over five months; and being in a first marriage. Exclusion criteria included: incomplete completion of the questionnaire (less than 92% of items answered) and completing the survey in less than two minutes.

After completing the MAS form, 70 women who scored below 100 were identified. Of these, 36 did not participate due to lack of eligibility, unwillingness to participate, lack of spousal or family permission, or other social issues. Ultimately, 34 women were randomly assigned to the intervention and control groups (Figure 1).

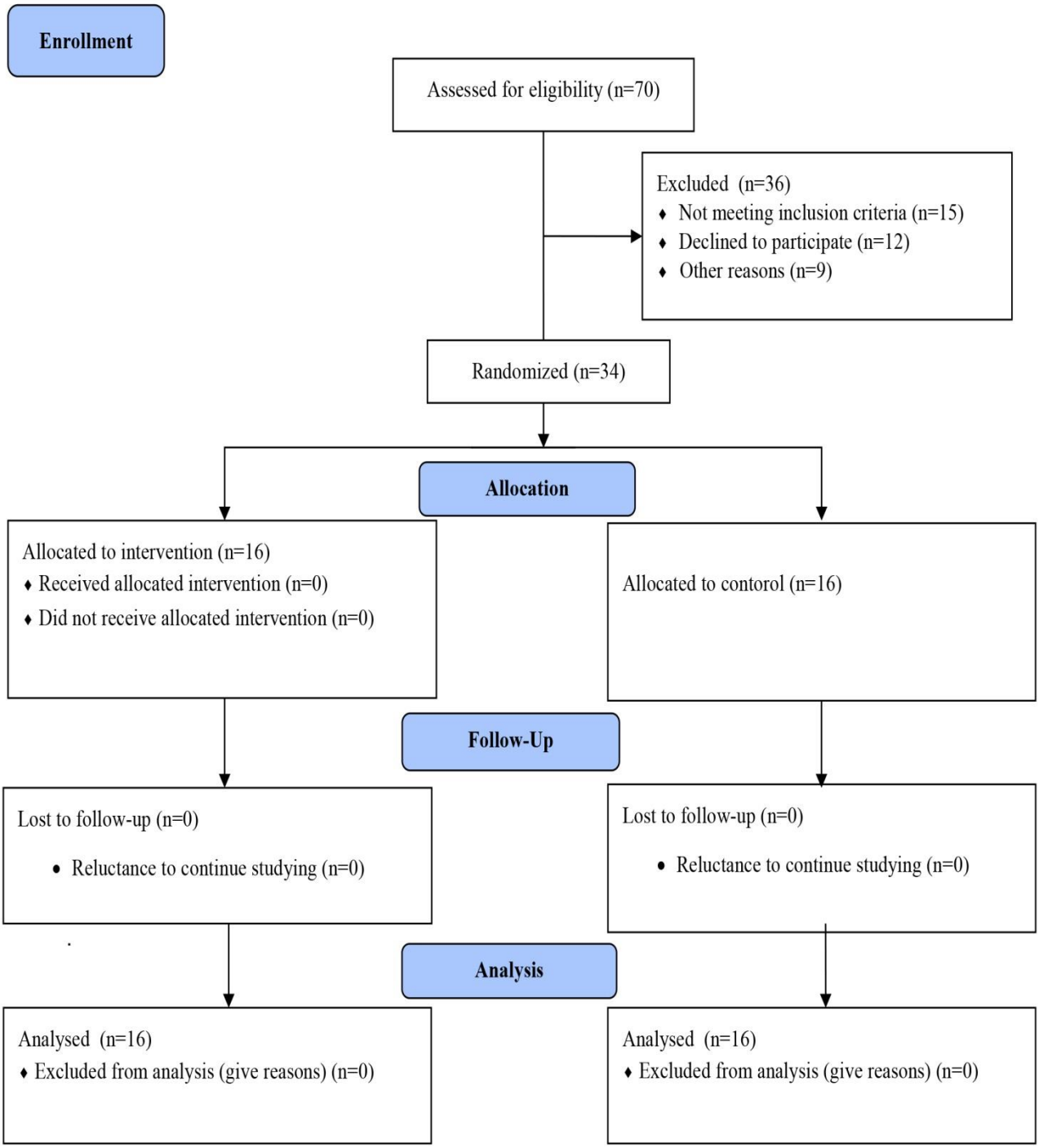

Figure 1: Flow Diagram for Patient Recruitment

Intervention

The researcher obtained the ethical approval code (IR.AJUMS.REC.1400.413) from the Research Officer of Ahvaz Jundishapur University of Medical Sciences, Ahvaz, Iran. Following this, and after the necessary coordination, permission was obtained from the Head of the Regional Courts (Judiciary and Family Court), as well as the Counseling and Divorce Boards and Prison Affairs. The researcher then referred to these centers, where eligible individuals were introduced to the study by the consultants of these institutions.

To ensure adherence to ethical standards, participants were informed about the purpose of the research, the procedures involved, the harmless nature of participation, and their right to withdraw at any time. Written informed consent was obtained from all participants before enrollment.

Participants were randomly assigned to two groups of 18 individuals each using a random number table. The control group received no intervention, while the experimental group participated in a reality therapy program consisting of 10 sessions, each lasting 90 minutes.

Group Reality Therapy (GRT) is a group counseling method in which individuals with similar or different problems gather in small groups and, under the guidance of a counselor, support each other in changing behaviors and achieving personal goals [24]. The educational content and session structure for this study were designed based on an extensive review of the literature [24-26].

Session one: Introducing group members and having them briefly describe themselves to establish rapport and state their reasons for participating in the group; setting rules for the sessions with members' participation and consultation; discussing session goals; introducing internal and external control theory; and discussing communication and its importance, with a focus on marital relationships.

Session two: Introducing and defining the five basic needs; discussing their characteristics, importance, and the role of each in happiness and well-being; exploring how to meet these needs in relationships; explaining the concept of responsibility from the perspective of choice theory; discussing dissatisfaction with basic needs and the limitations and contrasts in meeting these needs within relationships; providing a brief explanation of the Beck Depression Questionnaire and Rosenberg Self-Esteem Questionnaire; and administering these questionnaires as a pre-test.

Session three: Drawing a diagram comparing one half of each member's face with that of their spouse to illustrate similarities and differences in basic needs; guiding members on how to reach common ground in these differences by examining concrete examples from their own lives; re-emphasizing the concept of responsibility—being accountable for meeting our needs—and using relationships to facilitate this process.

Session four: How the qualitative world is created, its role in life, and its impact on our successes and failures; examining its characteristics and how to identify logical and illogical perceptions of reality; coping with others through sharing common perceptions and respecting their differing views from our own.

Session five: understanding conflicts between needs and between the self and others; distinguishing between false and real conflicts; recognizing common mistakes in handling conflicts; learning appropriate methods to address both types of conflicts; and explaining conflict resolution techniques.

Session six: Introduction to the seven destructive habits and their explanations; understanding how these habits are justified and used to control others, along with their consequences; familiarity with the seven connecting habits and their explanations to foster understanding; entering and sharing each other's qualitative world; and practicing conflict resolution techniques with two group members.

Session seven: Definition of behavior from the perspective of choice theory; explanation of the "behavior machine" as an analogy for general behavior, with its components represented as the front and back wheels of a machine; familiarization with emotional components and their significance in choosing unhappiness and suffering in life based on these emotions; understanding how to optimally use these components as guiding signs toward the right path in life and to meet needs; and learning how to change behavior by focusing on the components of action and thinking (cognition), which are directly controllable, thereby influencing and changing the emotional and physiological components.

Session eight: Introduction to creativity and the brain's creative system; familiarization with how creative and organized behaviors are formed; understanding the role of organized and repetitive behaviors in reducing adaptability; exploring the role of creativity in personal development; and emphasizing the importance of continuous enrichment of relationships.

Session nine: Familiarity with the external world or reality; understanding the characteristics of reality; introduction to the human sensory system ("sensory camera") and its function; explanation of general knowledge filters and evaluation filters; and exploration of the perceptual world and how it influences the qualitative world and overall behavior.

Session ten: Re-explanation of the chart by the researcher and one of the members to review the previous session; focus on the general knowledge filter as a point for review, enrichment, and modification of its content to influence the evaluation filter, the qualitative world, and consequently overall behavior; discussion about the status of women in society and family, legal issues, gender discrimination, and potential solutions. Before and after the intervention,

the Beck Depression Questionnaire and Rosenberg Self-Esteem Questionnaire were administered to evaluate self-esteem.

Instrument

Data collection tools included the Marital Adjustment Scale (MAS), Rosenberg's Self-Esteem Scale, and Beck's Depression Questionnaire.

The **Marital Adjustment Scale (MAS)** is a 15-item questionnaire that measures how well a married couple gets along across various domains such as agreement, affection, conflict, and satisfaction. Each item has a different score value depending on the response given. The total score ranges from 2 to 158, with higher scores indicating better marital adjustment. However, the interpretation of the score may vary depending on the norms of the population of interest. For example, according to a 1959 study, the cutoff point between happy and unhappy couples was set at 100; couples who scored above 100 were classified as happy, while those scoring below 100 were classified as unhappy. This cutoff point, however, may change across different societies and periods [27]. Isanezhad et al. confirmed the validity of the MAS in the Iranian population and reported a Cronbach's alpha of 0.76 for its reliability [28].

The Rosenberg Self-Esteem Scale (RSES) is a 10-item questionnaire that measures a person's overall self-perception, both positively and negatively. Five items are phrased positively, and five items are phrased negatively. Respondents indicate whether they agree or disagree with each statement. Scoring is done by assigning a value from 0 to 3 for each item, with higher values reflecting higher self-esteem. The negatively phrased items are reverse-scored. The total score ranges from 0 to 30, with higher scores indicating greater self-esteem. Generally, a score below 15 may suggest problematic low self-esteem [29]. In a study by Rajabi and Bohlol, the construct validity of the Persian version of the Rosenberg Self-Esteem Scale was assessed by correlating its total score with the Death-Obsession Scale (r = -0.34) in a sample of college students. The Persian version demonstrated good internal consistency, with a Cronbach's alpha of 0.84 [30].

The **Beck Depression Inventory (BDI-II)** is a 21-item questionnaire that measures the severity of depressive symptoms in individuals aged 13 and older. Each item corresponds to a symptom of depression, such as sadness, guilt, fatigue, or suicidal thoughts. Respondents select one of four statements that best describes how they have felt over the past two weeks. Each statement is scored from 0 to 3, with higher values indicating more severe depression. The total score ranges from 0 to 63, with higher scores reflecting greater severity of depression. According to the manual, a score below 13 indicates minimal depression; 14 to 19 indicates mild depression; 20 to 28 indicates moderate depression; and 29 or above indicates severe depression [24]. Taheri Tanjani confirmed the validity of the BDI-II in Iran and reported a Cronbach's alpha of 0.81 for its reliability [31].

The present study was approved by the Ethics Committee of Jundishapur University of Medical Sciences under the code **IR.AJUMS.REC.1400.413**. All necessary approvals for conducting the research were obtained from the relevant authorities, and all methods were carried out following applicable guidelines and regulations. After selecting participants, the study objectives and procedures were explained to them in detail. Written informed consent was obtained from all participants. The participants and their families were assured that no costs would be imposed on them. Moreover, the women participating in the study were guaranteed that all collected information would remain confidential and that the results would only be published in aggregate form for research purposes.

Data Analysis

The collected data were analyzed using SPSS software version 22. The Shapiro–Wilk test confirmed the normality of the data; therefore, the chi-square test was applied to compare the demographic characteristics between the two groups. To compare the self-esteem and depression scores between the two independent groups, the independent t-test was used. Additionally, the paired t-test was employed to compare pre- and post-intervention scores within each group. A significance level of $p < 0.05$ was considered for all analyses.

Result

The findings indicated that 53.1% of the participants were between the ages of 25 and 30, and 37.5% held a bachelor’s degree. There was no significant difference between the intervention and control groups regarding demographic variables ($P > 0.05$) (Table 1).

The independent t-test results showed that before the intervention, there was no significant difference in self-esteem scores between the two groups ($P = 0.756$). However, after the intervention, self-esteem in the intervention group was significantly higher compared to the control group ($P < 0.001$). Similarly, before the intervention, there was no significant difference in depression scores between the two groups ($P = 0.857$). In contrast, after the intervention, depression scores were significantly lower in the intervention group ($P < 0.001$) (Table 2).

The results of the paired t-test indicated no significant difference in self-esteem before and after the intervention in the control group ($P = 0.370$). In contrast, self-esteem increased significantly in the intervention group following group reality therapy (GRT) ($P < 0.001$). Similarly, no significant difference in depression scores was observed before and after the

intervention in the control group (P = 0.818). In contrast, depression scores significantly decreased in the intervention group after GRT (P < 0.001) (Table 3).

Table 1: Distribution of Demographic Variables between the Intervention and Control Groups

Demographic		Intervention (N=16)	Control (N=16)	Total (N=32)	f	*P-value
		N(%)	N(%)	N(%)		
Age	25-30	10 (62.50)	7 (43.80)	17 (53.10)	2.330	0.324
	31-40	3 (18.80)	7 (43.80)	10(31.30)		
	41-45	3 (18.80)	2(12.50)	5(15.60)		
Academic Level	High school	1 (6.30)	2(12.50)	3(9.40)	3.810	0.639
	Diploma	2 (12.50)	2(12.50)	4(12.50)		
	Technician	3 (18.80)	4 (0.25)	7(21.90)		
	BSc	8(50.00)	4 (0.25)	12(37.50)		
	MSc	2 (12.50)	2 (12.5)	4(5.12)		
	PhD	0 (0.0)	2 (12.5)	2(6.30)		
Occupation	Housewife	11 (68.80)	11 (68.80)	22 (68.80)	0.002	0.960
	Employee	5 (31.30)	5 (31.30)	10(31.30)		

* Chi-square test

Table 2: Comparison of the Mean Scores of Self-Esteem and Depression between the Intervention and Control Groups

Variable		Intervention Group (N=16)	Control Group (N=16)	f	*P-value
		Mean (SD)	Mean (SD)		
Self-Esteem	Before intervention	2.34(2.18)	2.44(2.16)	3.140	0.756
	After intervention	5.56(1.75)	2.13(2.33)	-6.084	P<0.001
Depression	Before intervention	27.81(10.23)	28.50(11.15)	0.182	0.875
	After intervention	11.13(4.95)	29.37(9.38)	6.880	P<0.001

* t-test

Table 3: Comparison of the Mean Scores of Self-Esteem and Depression Before and After the Intervention within Each Group

Variable		Before Intervention	After Intervention	f	P-value
		Mean (SD)	Mean (SD)		
Self-Esteem	Intervention group (N=16)	2.34(2.18)	5.56(1.75)	-5.910	P<0.001
	Control group (N=16)	2.44(2.16)	2.13(2.33)	0.924	0.370
Depression	Intervention group (N=16)	27.81(10.23)	11.13(4.95)	7.011	P<0.001
	Control group (N=16)	28.50(11.15)	29.37(9.38)	-0.235	0.818

*Paired t-test

Discussion

The results showed that group reality therapy (GRT) was effective in increasing self-esteem in the intervention group compared to the control group. These findings support the hypothesis that GRT improves the psychological well-being of women who have experienced infidelity. Moloud et al. (2022) reported that cognitive-behavioral group therapy (CBGT) significantly improved self-esteem and optimism in the intervention group compared to the control group immediately after treatment and at three- and six-month follow-ups [32]. However, the levels of these variables decreased over time after the intervention, suggesting the need for additional or booster sessions to maintain the effects. Firozi et al. (2018) indicated that group reality therapy significantly reduced rumination and increased self-esteem in the experimental group compared to the control group, which aligns with the present study [33].

These results are consistent with the theoretical framework of choice theory and reality therapy, which underlie GRT. According to choice theory, humans have five basic needs that drive their behavior: survival, love and belonging, power, freedom, and fun [34]. Infidelity can threaten these needs—especially love and belonging—and cause emotional distress and dissatisfaction in women [35]. Reality therapy helps women take responsibility for their choices and actions and evaluate how they are meeting their needs and fulfilling their quality of life. GRT helps women improve communication, responsibility, commitment, and satisfaction in their relationships. It also aids women in coping with the emotional pain and trauma caused by infidelity and rebuilding trust and intimacy in their relationships [33].

The results are also consistent with previous studies that have examined the effectiveness of group reality therapy (GRT) for various populations and issues, such as substance abuse, domestic violence, sexual dysfunction, juvenile delinquency, academic

achievement, and organizational management [36-39]. However, this study is among the first to provide empirical evidence on the effectiveness of GRT for couples who have experienced infidelity. Most prior research on GRT has focused on different populations or issues and employed diverse outcome measures and research designs [36-39].

Of course, it is not always the case that GRT increases self-esteem [40]. Many factors may influence the effectiveness of Glasser's reality therapy on self-esteem, such as participant characteristics, the duration and frequency of sessions, the content and quality of the intervention, and the outcome measures used [32]. Reality therapy may help participants cope with their situation by providing a supportive and empathic environment where they can learn to accept reality, make positive choices, and develop new skills and strategies. However, other studies have targeted women with low self-esteem for different reasons, such as living alone or being college students. In these cases, reality therapy may not have been sufficient or appropriate for addressing their specific needs and challenges, such as loneliness, academic stress, or social anxiety.

The results of the present study showed that GRT was effective in decreasing depression among betrayed women in the intervention group compared to the control group. Jabro et al. reported that reality therapy reduced depression [41]. Kudang et al. also found that reality therapy helps these women cope with their depression [41]. However, reality therapy interventions are not always effective in reducing depression [42]. The content and quality of the intervention may influence the effectiveness of reality therapy. For example, some studies have combined reality therapy with other approaches, such as cognitive-behavioral therapy [43] or art therapy [44]. These combinations may enhance or diminish the effects of reality therapy depending on how well they complement each other and address the needs of the participants. Additionally, some studies have used different versions or adaptations of reality therapy, such as Glasser's group reality therapy or other group reality therapy models [45]. These versions may differ in emphasis or components, such as focusing on self-evaluation or relationship building. Furthermore, some studies have varied in the quality of intervention delivery, including the training and experience of therapists, the rapport and interaction with participants, and the fidelity and adherence to the intervention protocol [43, 46].

This finding suggests that group reality therapy (GRT) is a promising intervention for reducing depression in women who have experienced marital betrayal. One possible mechanism of action of GRT is that it helps women change their negative thoughts and behaviors that contribute to their depression [20]. For example, clients may learn to identify and challenge their irrational beliefs, such as "I am worthless because my husband cheated on me" or "I have no control over my life". Clients may also learn to replace their self-defeating behaviors, such as isolating themselves or blaming themselves, with more positive and constructive ones, such as seeking support or engaging in hobbies [47].

Another possible mechanism of action of GRT is that it enhances clients' coping skills and resilience. For instance, clients may learn to accept reality and deal with it effectively, rather than denying or avoiding it. They may also learn to make plans for change and take steps to achieve their goals, rather than feeling hopeless or helpless. Furthermore, clients may develop strategies to cope with stress and negative emotions in healthy ways, such as through relaxation or humor [48].

A third possible mechanism of action of GRT is that it improves clients' relationships with others. For example, clients may learn to communicate their needs and feelings more assertively and respectfully, rather than passively or aggressively. They may also learn to listen to and empathize with others more attentively and sincerely, rather than judging or criticizing them. Additionally, clients may learn to build trust and intimacy with others more confidently and securely, rather than fearing or avoiding them [49].

These mechanisms of action may explain why GRT effectively decreased depression in the intervention group compared to the control group. However, more research is needed to confirm these explanations and to explore other factors that may influence the outcomes of this intervention, such as the duration, frequency, and content of the sessions, as well as the characteristics and needs of the participants [50].

The limitations of the study included the fact that the statistical population consisted of a specific group in society—women affected by spousal infidelity in the city of Ahvaz—which limits the generalizability of the results to other populations. Participants voluntarily participated in the experiment during the initial selection process, so the social desirability effect may have influenced the results.

Conclusion

This study showed that GRT was effective in increasing self-esteem and decreasing depression in women who had experienced infidelity, compared to a control group that received no intervention. These findings support the hypothesis that GRT can improve the psychological well-being of women affected by infidelity. They also align with the theoretical framework of choice theory and reality therapy, which underpin GRT. Therefore, it is recommended that relevant institutions organize regular rehabilitation programs based on GRT for betrayed women.

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Author Contributions

Sh.M. and H.K. designed the study. S.Gh. and Sh. M collected and analyzed data. H.K. and B.D. wrote the manuscript. S.Gh. and Sh.M. revised the manuscript. All authors read and approved the final version of the manuscript.

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Data Availability Statement

The dataset supporting the conclusions of this article is included within the article.

Declaration

Consent for Publication: Not applicable
Conflict of Interest: The authors declare no conflict of interest.

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